(1) Supreme Court, U.S.
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No. _____

In The

Supreme Court of the United States

RCJ MEDICAL SERVICES, INC.,

Petitioner,

vs.

THE DIRECTOR OF THE CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES,

Respondent.

On Petition For A Writ Of Certiorari To The Court Of Appeal Of The State Of California Second Appellate District

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the approval by the United States Department of Health and Human Services of a Medicaid State Plan Amendment, purporting to allow a single state Medicaid agency to delegate to another state office administrative authority to conduct a postpayment review of the records of a Medicaid provider, including medical records, violates the governing federal Medicaid regulation, 42 C.F.R. § 431.10(e) [1999], which states that a single state Medicaid agency "must not delegate, to other than its own officials, authority to exercise administrative discretion."

2. Whether, in any event, such delegation of administrative authority may be commenced prior to the "effective date" of the State Plan Amendment, approving of the delegation under the controlling federal Medicaid regulations, 42 C.F.R. §§ 430.10 and 430.20 [1999].

LIST OF PARTIES AND RULE 29.6 DISCLOSURE

The parties to the proceedings below were the Petitioner, RCJ Medical Services, Inc., and the Director of the California State Department of Health Services. RCJ Medical Services, Inc., is a California corporation which is not a publicly held corporation and has no stockholder which is a publicly owned corporation.

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PETITION FOR WRIT OF CERTIORARI

Petitioner, RCJ Medical Services, Inc. ("RCJ"), respectfully prays that a Writ of Certiorari issue to review the opinion of the California Court of Appeal, Second Appellate District (Division Five), filed August 23, 2001. The California Supreme Court denied RCJ's Petition to Review the decision of the Court of Appeal on December 12, 2001, and the Remittitur issued December 28, 2001, confirming that the Court of Appeal's decision had "now become final."

OPINIONS BELOW

The August 23, 2001, published opinion of the California Court of Appeal, Second Appellate District, is reported at 91 Cal.App.4th 986; 111 Cal. Rptr. 2d 223 (Ct. App.2001), and is reprinted in the Appendix at 1-38. The August 30, 2001, order of the Court of Appeal denying RCJ's Petition for Rehearing is reprinted in the Appendix at 39.

The decision of the California Supreme Court of December 12, 2001, denying RCJ's Petition for Review is reprinted in the Appendix at 75. The December 28, 2001, Remittitur is reprinted in the Appendix at 74.

The May 18, 2000, Judgment of the Superior Court of the State of California for the County of Los Angeles in favor of RCJ, the Judgment which was reversed by the California Court of Appeal's August 23, 2001, decision, is reprinted in the Appendix at 40-41.

The August 6, 1999, Final Decision of the Director of the California Department of Health Services, which gave rise to the decisions of the California Superior Court and the California Court of Appeal, is reprinted in the Appendix at 42-73.

JURISDICTION

As indicated above, the decision of the California Court of Appeal, Second Appellate District, for which this Petition for Writ of Certiorari is being sought, was filed by the California Court of Appeal on August 23, 2001. The decision of the California Supreme Court denying RCJ's Petition to Review the decision of the California Court of Appeal was filed December 12, 2001. On December 28, 2001, the Court of Appeal issued a Remittitur confirming that its August 23, 2001, decision had become final.

The decision of the California Court of Appeal involves questions of federal law, including whether the implementation of a state Medicaid Plan Amendment violates the provisions of the governing federal Medicaid laws and regulations, which under the United States Constitution, are supreme to state laws, regulations, and policies. Thus, jurisdiction exists under 28 U.S.C. § 1257. Moreover, because the decision of the California Court of Appeal (1) directly conflicts with another decision of the same court on the very same issue; (2) indirectly conflicts with the decisions of the United States Court of Appeals for the Ninth Circuit on very similar issues; and (3) resolves questions which have not been, but should be,

settled by this Court, jurisdiction also exists pursuant to Rule 10 of the Rules of this Court.

STATUTES AND REGULATIONS

This case involves the administration of the Medicaid program, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* and 42 C.F.R. §§ 430.1 *et seq.* [1999]. The Medicaid program is jointly administered by the federal and state governments. Each state's Medicaid program must be administered pursuant to its state Medicaid plan. *See* 42 U.S.C. § 1396 and 42 C.F.R. § 430.10 [1999]. A Medicaid State Plan must contain various provisions required by the Medicaid laws and regulations. *See* 42 U.S.C. § 1396a(a)(1)-(65) and 42 C.F.R. §§ 431.1 *et seq.* [1999]. These federal requirements are supreme to state law requirements regarding the administration of the Medicaid Program. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990).

Each Medicaid State Plan must designate a single state agency to administer or to supervise the administration of its State Plan, except that the determination of eligibility for medical assistance under a State Plan may be made by a local agency subject to the supervision of the single state agency. *See* 42 U.S.C. § 1396a(a)(5), and 42 C.F.R. § 431.10 [1999]. Appendix at 76, 79.

Under 42 C.F.R. § 431.10(e) (Appendix at 82), the single state agency "must not delegate, to other than its own officials, authority" to "exercise administrative discretion" in the administration of the plan.

The Medicaid statutes and regulations specify those limited exceptions where the single state Medicaid agency may delegate authority to other state or local agencies, such as for purposes of determining Medicaid eligibility (42 U.S.C. § 1396a(a)(5)), and for purposes of establishing and maintaining health and other standards for Medicaid providers (42 U.S.C. § 1396a(a)(9) and 42 C.F.R. § 431.610 [1999]). Appendix at 76, 84. *See, also,* 42 C.F.R. §§ 431.615, 431.621, and 431.630 [1999], all of which allow the single state Medicaid agency to enter into relationships with other state agencies. However, these interagency relationships must be described in the State Medicaid Plan. For example, *see* 42 C.F.R. § 431.610(b) and (c) [1999], Appendix at 84-85.

In addition to requiring each State Medicaid Plan to describe the single state Medicaid agency's relations with *other* state and local agencies, the State Medicaid Plan must also describe the organization and functions of the single state Medicaid agency, itself, and its personnel and supporting staff. *See* 42 U.S.C. § 1396a(a)(22) and 42 C.F.R. § 431.11(c) [1999]. Appendix at 77, 83.

The single state Medicaid Plan must provide for Medicaid claims payment procedures which assure that claims are paid on time. However, the State Plan must also provide for procedures for prepayment and postpayment claims review to ensure the proper and efficient payment of claims and management of the Medicaid Program. 42 U.S.C. § 1396a(a)(37) and 42 C.F.R. § 447.45 [1999], Appendix at 78, 85-89. Under 42 C.F.R. § 447.45(f), the single state Medicaid agency must conduct the prepayment and postpayment reviews. There is no Medicaid statute or regulation permitting such postpayment and

prepayment reviews to be delegated by the single state Medicaid agency to another state agency.

To facilitate the postpayment and prepayment reviews required to be conducted by the single state Medicaid agency, the state Medicaid Plan requires agreements pursuant to which health care providers must maintain certain records and must furnish those records and other information to the single state Medicaid agency or to the Secretary of the United States Department of Health and Human Services ("U.S. DHHS"). *See* 42 U.S.C. § 1396a(a)(27). Appendix at 77.

State Plan Amendments must be submitted by the single state agency and approved by U.S. DHHS when there are material changes in the organization or policy of the state Medicaid program. *See* 42 C.F.R. § 430.12(c)(1)(ii) [1999]. Appendix at 79. Plan amendments, which do not affect Medicaid eligibility and payment methods and standards, become effective on the date requested by the single state Medicaid agency if U.S. DHHS approves the Plan Amendment. *See* 42 C.F.R. § 430.20(b)(3) [1999]. Appendix at 80.

STATEMENT OF THE CASE

A. STATEMENT OF THE FACTS

The California Department of Health Services ("State DHS") is the single state Medicaid agency for California's Medicaid program, known as the Medi-Cal program. In the California State Medicaid Plan submitted to U.S. DHHS in 1993, State DHS was identified as the single

state Medicaid agency for all purposes, including conducting postpayment audits and reviews of providers. *See* Court of Appeal decision, Appendix at 14.

On July 1, 1997, State DHS and the California Controller's Office, which is *not* part of State DHS, entered into an Interagency Agreement (without amending the State Plan) purporting to authorize the State Controller to perform audit services relating to the Medi-Cal program. Court of Appeal Decision, Appendix at 14.

Acting pursuant to the July 1, 1997, Interagency Agreement, the State Controller conducted a postpayment review of RCJ's Medi-Cal claims for the period from January 9, 1997, to October 9, 1997, and a subsequent postpayment review for the period from October 10, 1997, to March 26, 1998. Court of Appeal decision, Appendix at 15-16. The State Controller issued her postpayment review findings in reports dated March 10, 1998, and May 4, 1998. RCJ then requested an administrative appeal to challenge the determinations of the State Controller.[1]

On June 15 and 16, 1998, an administrative hearing was held before an administrative law judge employed by State DHS. Among other challenges to the Controller's

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[1] The State controller's postpayment review of RCJ was not simply a financial audit or review. Rather, the State controller analyzed confidential medical records, interviewed physicians, patients and their relatives, and made judgmental determinations regarding the medical necessity of certain laboratory tests performed by RCJ. *See* Final Decision of State DHS, Appendix at 63-67. Thus, in conducting the postpayment review, the State Controller exercised considerable administrative discretion.

findings, RCJ asserted at the hearing that the State Controller lacked authority under the controlling federal Medicaid laws and regulations to perform Medi-Cal postpayment reviews. RCJ argued that under the governing federal Medicaid laws and regulations and the then-existing provisions of the State Medicaid Plan, only State DHS, the single state Medicaid agency, could conduct postpayment reviews of providers' records and claims. On August 5, 1999, the Chief Deputy Director for State DHS issued a final agency decision granting RCJ's appeal in part and denying it in part. However, the State DHS Deputy Director concluded that the State Controller had the authority to conduct the postpayment review of the Medi-Cal claims at issue under federal Medicaid laws and regulations. *See* Final Decision of State DHS, Appendix at 48-52.

State DHS issued its August 5, 1999, Final Decision upholding State DHS' authority to delegate audit and review authority to the State Controller notwithstanding the fact that the California Court of Appeal had issued a decision in February 1999, which became final on May 26, 1999 (after the California Supreme Court denied the State Controller's Petition for Review), expressly holding that the controlling federal Medicaid regulation, 42 C.F.R. § 431.10(e)(1) [1999] (Appendix at 82), prohibited State DHS from "delegating to the State Controller the audit of claims by medical services providers and the withholding of alleged overpayments." *See Doctor's Medical Laboratory, Inc. v. Connell*, 69 Cal.App.4th 891, 893 (1999). Appendix at 99. In *Doctor's*, the very same (but different division of the) California Court of Appeal that issued the decision here concluded that "the Controller could not lawfully exercise power to audit provider payments and withhold

alleged excesses." 69 Cal.App.4th at 897. Appendix at 106.

On December 17, 1999, after losing the issue before the Court of Appeal in *Doctor's*, State DHS submitted a State Plan Amendment to U.S. DHHS to provide that the State Controller's Office performs audits of Medi-Cal expenditures on behalf of State DHS. *See* December 17, 1999, transmittal letter and State Plan Amendment, copy attached, Appendix at 91-94. State DHS specifically requested a July 1, 1998 effective date for the State Plan Amendment. *Id.*

On that same day, December 17, 1999, U.S. DHHS informed State DHS that it had, in fact, approved the State Medicaid Plan to reflect that the State Controller's Office performs audits of Medi-Cal expenditures on behalf of State DHS. U.S. DHHS made its approval effective July 1, 1998, as requested by State DHS. *See* the December 17, 1999, transmittal letter and federal approval, copy appended at 95-98.

In the meantime, RCJ had initiated a challenge to the State DHS' Final Decision by filing a Petition for Writ of Mandate in the California Superior Court for the County of Los Angeles on October 28, 1999, pursuant to California Welfare and Institutions Code Section 14171. Court of Appeal Decision, Appendix at 19.

B. THE COURSE OF THE PROCEEDINGS BELOW

On May 19, 2000, the California Superior Court for the County of Los Angeles issued a Judgment granting RCJ's request for a peremptory writ of mandate setting aside the Final Decision of State DHS "insofar as it relied

upon the audit findings of the State Controller." Appendix at 40-41.

The Director of State DHS appealed the Superior Court's Judgment to the California Court of Appeal. On August 23, 2001, the California Court of Appeal, Second Appellate District, issued a decision reversing the Judgment of the Superior Court. The California Court of Appeal contended it did not have to follow the previous decision of the Court in *Doctor's* because *Doctor's* had been issued before State DHS had submitted and the federal government had approved the December 17, 1999, State Plan Amendment describing for the first time in the Plan the Controller's role in auditing Medi-Cal providers. Appendix at 21-23.

In its August 23, 2001 decision, the Court of Appeal concluded that U.S. DHHS' approval of the December 17, 1999, State Plan Amendment constituted that agency's interpretation of the governing federal Medicaid regulations and statutes. And, according to the California Court of Appeal, even though the federal Medicaid regulation at issue, 42 C.F.R. § 431.10(e) (which had not changed since *Doctor's* was decided), expressly prohibits the delegation of administrative discretion by the single state Medicaid agency to another state agency, the federal government's approval of the State Plan Amendment was reasonable and entitled to controlling deference.

Although the California Court of Appeal relied heavily on the December 17, 1999, State Plan Amendment to distinguish its holding in RCJ's case from its previous holding in *Doctor's* and to permit State DHS to delegate authority to the State Controller, the Court disregarded the legal impact of the Plan Amendment's July 1, 1998,

effective date. Thus, even though the State Controller audited RCJ while the State Plan indicated that only State DHS did so and well before July 1, 1998, the effective date of the Plan Amendment, the Court seemingly allowed the Plan Amendment to be applied to RCJ (without expressly deciding the issue of the legal impact of the plan amendment's effective date). Appendix at 23.

Following the denial of RCJ's Petition for Rehearing, RCJ petitioned the California Supreme Court to review the August 23, 2001 Opinion of the Court of Appeal. RCJ asked the California Supreme Court to determine (1) whether the controlling federal Medicaid regulations permitted State DHS to delegate to the State Controller the authority to perform prepayment and postpayment reviews of Medicaid providers, and (2) whether the federal government's December 17, 1999, approval of State DHS' Medicaid Plan Amendment was applicable to the postpayment review at issue in this case since the audit had been completed prior to July 1, 1998, the effective date of the federal approval. On December 12, 2001, the California Supreme Court denied RCJ's petition. Appendix at 75.

SUMMARY OF WHY THE AUGUST 23, 2001 DECISION IS WRONG

Single state Medicaid agencies, and only single state Medicaid agencies, are authorized to perform postpayment reviews under the controlling federal statute, 42 U.S.C. § 1396a(a)(37) (Appendix at 78), and federal regulation, 42 C.F.R. § 447.45(f) (Appendix at 89-90). Unlike a few other circumstances, neither the Medicaid statutes

nor regulations expressly permit a single state Medicaid agency to delegate such authority to another agency. Thus, the general regulatory prohibition of 42 C.F.R. § 431.10(e) (Appendix at 82) prohibiting such delegation of administrative discretion is clearly applicable, as the California Court of Appeal decided in *Doctor's*.

Because the language of the controlling regulation is plain – *i.e.*, the single state Medicaid agency must *not* delegate administrative discretion to another state agency – it must be applied by the Courts. The State Court of Appeal erred here by allowing the December 17, 1999, Plan Amendment to "trump" the plain language of the regulation. The Court also should not have considered "legislative history," which purports to contradict the plain language of the regulation.

In any event, the State Plan must describe those agencies and personnel performing administrative duties. 42 U.S.C. § 431.11(c), Appendix at 83. At the time the State Controller conducted the postpayment review of RCJ, the California State Medicaid Plan specified that postpayment reviews were done solely by State DHS. *See Doctor's*, Appendix at 14. Indeed, even after the plan was amended retroactively in December 1999, its July 1, 1998 effective date *postdated* the State Controller's audit of RCJ. Thus, the Controller's postpayment review of RCJ was inconsistent with the then-existing provisions of the State Medicaid Plan and therefore void.

REASONS FOR GRANTING THE WRIT

A. THE DECISION OF THE COURT OF APPEAL CONFLICTS DIRECTLY WITH ITS PREVIOUS DECISION IN *DOCTOR'S* ON AN IMPORTANT QUESTION OF FEDERAL LAW.

As explained above, the very same Court of Appeal (but a different Division and therefore a different panel of judges) concluded in *Doctor's* (Appendix at 99-107) that the governing federal Medicaid law prohibits State DHS from delegating postpayment review authority to the State Controller. In doing so, the California Court of Appeal interpreted the very same regulatory provisions interpreted by the Court of Appeal in this case, 42 C.F.R. § 431.10(e).[2]

The wording of this federal Medicaid regulation (and the other relevant regulations) did not change between the date the Court issued its decision in *Doctor's* and the date it issued its decision in this case. The only relevant event that occurred between the two decisions, according to the Court of Appeal, was the federal government's approval of the December 17, 1999, State Plan

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[2] That the federal Medicaid statutes and regulations are supreme to state laws, rules and policies is well established. *See, e.g., Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990). Moreover, unlike the often problematical situation where providers seek to enforce the federal medicaid laws and regulations in *federal court*, such as in the recently issued decision of the Ninth Circuit in *San Lazaro Ass'n, et al. v. Connell, et al.*, Nos. 00-55065, et al., Jan. 24, 2002 W.L. 89073, ___ F.3d ___ (9th Cir. 2002), California statutes permit a provider to do so in state court under California Code of Civil Procedure § 1094.5. *See* Court of Appeal decision, Appendix at 20-21.

Amendment, which the Court construed as a dispositive intervening interpretation by the federal agency responsible for administering the Medicaid program.

As mentioned above, this intervening event, however, may *not* alter the plain meaning of the governing federal Medicaid regulation. In actuality, it is quite clear that the Panel of Judges who decided this case simply disagreed with the reasoning of the Panel of Judges who decided *Doctor's*, thus presenting a classic conflict of court decisions. Because the California Supreme Court refused to review either case, there remains a clear and direct conflict between two Panels of the same state Court of Appeal over the appropriate interpretation of the controlling federal Medicaid laws and regulations. Pursuant to Rule 10(b), this Court may resolve that conflict.

Indeed, because it is difficult for providers to enforce federal Medicaid regulations in *federal* court (*see*, fn. 2, *supra*, and *Sobky v. Smoley*, 855 F. Supp. 1123, 1144 (E.D. Cal. 1994) [even though 42 C.F.R. § 431.10(e) imposes a mandatory duty on states, providers may not enforce that right in *federal* court]) it is critical that *state* courts correctly interpret federal Medicaid laws and regulations.

B. THE DECISION OF THE CALIFORNIA COURT OF APPEAL ALSO INDIRECTLY CONFLICTS WITH THE DECISIONS OF THE UNITED STATES COURT OF APPEALS AND THE CALIFORNIA COURT OF APPEAL REGARDING THE DEFERENCE TO BE GIVEN ADMINISTRATIVE AGENCIES' INTERPRETATIONS AND REGARDING THE ISSUE OF THE EFFECTIVE DATE OF MEDICAID STATE PLAN AMENDMENTS.

As indicated above, the California Court of Appeal in this case treated the federal government's approval of State DHS' December 17, 1999, Plan Amendment as an "official" interpretation of the governing federal Medicaid laws and regulations. The Court then essentially proceeded to give complete deference to that interpretation. In doing so, the Court ignored the basic principle of administrative law requiring no such deference be given when the plain language of a statute or regulation is clear.

The controlling federal Medicaid regulation, 42 C.F.R. § 431.10(e), expressly provided during all periods at issue that the single state Medicaid agency "must not delegate to other than its own officials, authority to . . . exercise administrative discretion in the administration or supervision of the plan." While the Medicaid statutes and regulations allow for some specific exceptions to the prohibition against delegation in particular situations, they do not specify an exception permitting the delegation of prepayment or postpayment authority from the single state Medicaid agency to another agency. Rather, as indicated above, the governing Medicaid statute, 42 U.S.C. § 1396a(a)(37), and regulation, 42 C.F.R. § 445.45(f),

expressly require the single state Medicaid agency to perform postpayment and prepayment reviews. Therefore, the plain language of Section 431.10(e)(1) prohibiting delegation of administrative discretion is fully applicable here. Because the plain language is mandatory and unambiguous, it is not subject to agency or judicial interpretation. It must be applied and followed regardless of whether the agency (or a court) prefers different language.

Recently, in *Alhambra Hospital v. Thompson*, 259 F.3d 1071 (9th Cir. 2001), the Court of Appeals applied the plain meaning of a Medicare regulation notwithstanding a contrary interpretation of the regulation by U.S. DHHS. In doing so, the Court concluded that not every U.S. DHHS regulation is of "delphic obscurity, explicable only through the Secretary's oracular powers." 259 F.3d at 1076. That is certainly true here, where the plain language of the governing regulations prohibits the delegation of discretionary authority by the single state Medicaid agency to another agency.

The Ninth Circuit has also upheld the plain language of the *Medicaid* statutes even when U.S. DHHS has approved a plan amendment based on a contrary interpretation of the statute. *See, for example, Childrens Hospital and Health Center v. Belshe*, 188 F.3d 1090, 1098 (9th Cir. 1989). Because the state courts are required to interpret regulations using the same rules applicable to statutory interpretation (*see Forrest v. Trustees of Cal. State University & Colleges*, 160 Cal.App.3d 357, 362 (1984), the state court should also have applied the plain language of the Medicaid regulations even if U.S. DHHS approved of a plan amendment that was contrary to such plain language.

The Court of Appeal bolstered its holding in this case by relying on so-called "legislative history" from agency handbooks, which the Court found to be consistent with U.S. DHHS' interpretation of the Medicaid regulations. However, reliance on legislative history is misplaced when the language of a statute or regulation is clear. Where the plain language is clear, it must be followed by a reviewing court and may not be disturbed by "supplementary information" published by the agency in the Federal Register. *See Wileman Bros. & Elliott, Inc. v. Giannini*, 909 F.2d 332, 336 (9th Cir. 1990).

These holdings of the Ninth Circuit are consistent with the holdings of this Court, which has confirmed that there is no need to consider legislative history when the language of a statute or regulation is plain. *See Connecticut National Bank v. Germaine*, 503 U.S. 249, 254 (1992). Unfortunately, the State Court of Appeal decision ignores this principle, which is fundamental to the rule of law.

The California Court of Appeal, itself, in other cases has recognized that it must apply the plain language of a regulation even if an agency has a "better idea," or the administrative agency believes the language of the regulation is not consistent with good public policy. *See Private Industry Council v. Employment Development Department*, 57 Cal.App.4th 1290, 1294 (1997) [federal law must be followed even if an agency "has a better idea."] *See, also, United States ex rel. Rahman v. Oncology Associates, Inc.*, 198 F.2d 502, 514 (4th Cir. 1999), holding that the U.S. DHHS is not excused from complying with its own federal regulations just because it believes the language of the regulations is not in the public interest.

Not only does the California Court of Appeal's decision in this case conflict with the decisions of the Ninth Circuit and the California Court of Appeal with respect to the interpretation of the plain language of a federal regulation, the decision also conflicts with those court decisions prohibiting Medicaid actions which are not authorized by the Medicaid State Plan. *See, for example, Exeter Memorial Hospital Association v. Belshe*, 943 F. Supp. 1239, 1240 (E.D. Cal. 1996), *aff'd*, 145 F.3d 1106, 1109 (9th Cir. 1998) [the Court prohibits State DHS' action from being implemented prior to the effective date of a state plan amendment] and *Oregon Association of Homes v. State Department of Human Resources*, 5 F.3d 1239 (9th Cir. 1993) [state Medicaid policy invalid because it was not submitted as a plan amendment to the federal government]. *See, also, Washington State Health Facilities v. State of Washington*, 698 F.2d 964 (9th Cir. 1982) and *Washington State Health Facilities v. DSHS*, 879 F.2d 677 (9th Cir. 1989).

In fact, the decision of the state Court of Appeal in this case with respect to the effective date of the Plan Amendment is also inconsistent with the California Court of Appeal's previous decisions. For example, in *Bingham v. Obledo*, 147 Cal.App.3d 401 (1983), the California Court of Appeal invalidated State DHS' reliance on state regulations because they were not part of the state Medicaid plan. Here, State DHS has relied on a postpayment review conducted by the State Controller before July 1, 1998, the effective date of the Plan Amendment permitting such reviews by the State Controller.

C. THE IMPORTANCE OF THE FEDERAL QUESTIONS TO BE RESOLVED.

State DHS, the California Controller's Office, and U.S. DHHS have represented to various courts on various occasions in this case and in related cases, including the *Doctor's* case, the importance of properly resolving the question of whether the federal Medicaid laws and regulations, as currently written, permit a single state Medicaid agency to delegate postpayment review authority to another state agency. For example, when the State Controller was unsuccessful on this issue before the California Court of Appeal in *Doctor's*, she requested the California Supreme Court to review the Court of Appeal's decision because it was a "matter of significant public interest." *See* page 4 of the State Controller's Petition for Review in *Doctor's*, filed on or about March 15, 1999. State DHS fully supported this request.

Indeed, the California State Controller, has even appeared before the United States Congressional House Commerce Committee's subcommittee on oversight and investigations urging Congress "to revise" federal Medicaid laws and regulations "regarding the role of the single state agency" to "allow" the California State Controller and other fiscal agents to perform Medicaid audits. *See* "Fraud in the California Medi-Cal Program," dated July 18, 2000, available at www.sc.ca.gov.

In this very case, State DHS presented the California Court of Appeal with a copy of the amicus brief of U.S. DHHS filed in the United States Court of Appeals for the Ninth Circuit in the case of *San Lazaro Ass'n, et al. v. Connell, et al.*, Case Nos. 00-55065, *etc., et al.* In requesting

permission to file its amicus curiae brief in those consolidated cases, U.S. DHHS characterized the question presented as one of first impression which is significant to the nationwide administration of the Medicaid program. *See* State DHS' Supplemental Motion for Judicial Notice and Memorandum of Points and Authorities filed with the California Court of Appeal on or about May 3, 2001.

Moreover, as pointed out by the California Court of Appeal in *Doctor's* (Appendix at 106-107), it is critical that the appropriate persons conduct postpayment reviews. In this case, financial auditors from the State Controller's Office discussed confidential medical procedures with patients in front of their relatives and friends to try to determine whether laboratory testing had been ordered and performed. *See* Exhibit 89 of the administrative record. When agencies other than the single state Medicaid agency conduct postpayment and prepayment reviews, the confidentiality of sensitive medical information will necessarily be jeopardized. This result is inconsistent with the strong public policy of protecting such information. *See* recent discussion of the Health Insurance Portability and Accountability Act of 1996, *codified* at 42 U.S.C. §§ 1320d-1320d-8 in rules issued by U.S. DHHS on December 8, 2000, 65 Fed. Reg. 82,798-82,829.

In addition to being important to the ongoing administration of the Medicaid program, the correct resolution of the issues presented is also critical to the application of federal administrative law principles by state courts. The California Court of Appeal here erroneously deferred to the agency's interpretation of the plain language of the

governing regulation rather than insisting that the plain language controls.

Finally, the rule of law is at stake. While U.S. DHHS and State DHS (as well as the Court of Appeal) might believe the prohibition against the delegation of postpayment review authority from the single state Medicaid agency to another agency is ill conceived or unwise, the Court must apply laws and regulations as written. *See* Justice Scalia's dissenting opinion in *Regents Hosp. v. Shalala*, 522 U.S. 448, 469 (1998) ["the immediate benefit achieved by such a practice (*i.e.*, rewriting the laws) in a particular case is far outweighed by the disruption of legal expectations in *all cases* – disruption of the *rule of law* – that government by ex post facto legislative psychoanalysis produces."][3]

CONCLUSION

The California Court of Appeal's decision interpreting the governing federal Medicaid laws and regulations is inconsistent with its own previous decision in *Doctor's* and is also inconsistent with decisions of the United States Court of Appeals for the Ninth Circuit. In order to assure uniformity in the administration of the Medicaid program and in the decisions of the courts, this Court is respectfully requested to grant the petition for a writ of

[3] The administration of the Medicaid program is also threatened by the Court of Appeal's decision ignoring the July 1, 1998, effective date of the Plan Amendment. Indeed, the Court of Appeal's decision renders meaningless the regulation regarding "effective dates."

certiorari to decide the important questions of law raised by this petition.

Dated: February 27, 2002

Respectfully submitted,

PATRIC HOOPER
HOOPER, LUNDY & BOOKMAN, INC.
Attorneys for Petitioner

APPENDIX

CERTIFIED FOR PUBLICATION

IN THE COURT OF APPEAL OF THE
STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FIVE

RCJ MEDICAL SERVICES, INC., Plaintiff and Respondent, v. THE DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES, Defendant and Appellant.	B143160 (Super. Ct. No. BS060056) (Filed Aug. 23, 2001)

APPEAL from a judgment of the Superior Court of Los Angeles County, David P. Yaffe, Judge. Reversed.

Bill Lockyer, Attorney General, Charlton G. Holland, III, Senior Assistant Attorney General, John H. Sanders, Lead Supervising Deputy Attorney General; and Patricia L. Nagler, Deputy Attorney General, for Defendant and Appellant.

Hooper, Lundy & Bookman, Inc., and Patric Hooper for Plaintiff and Respondent.

I. INTRODUCTION

This case involves a postpayment audit of a Medi-Cal provider's claims. Such audits are required under both federal and state law. (42 C.F.R. §§ 447.45(f)(2), 456.3; Welf. & Inst. Code, § 14170, subd. (a)(1).) No Medi-Cal payments were withheld from the provider.

The State Department of Health Services (DHS) administers Medi-Cal, the federal Medicaid program in California. The DHS contracted with the State Controllers' office (the Controller) to audit Medi-Cal payments to providers. The Health Care Financing Administration (HCFA), part of the United States Department of Health and Human Services, is the federal agency responsible for administering the Medicaid program. On December 17, 1999, the HCFA, a federal agency, specifically approved in writing the DHS's delegation of audit authority to the Controller.

This appeal is from a judgment granting a peremptory writ of administrative mandate directed at defendant, the Director of the DHS. The peremptory writ of mandate requires the DHS to set aside its final decision in the administrative appeal of RCJ Medical Services, Inc. (RCJ), "insofar as it relies upon the audit findings of the State Controller. . . . " RCJ contends federal Medicaid law, and specifically the single state agency requirement, precludes the DHS's delegation of audit authority to the Controller.[1] The question in this case is whether the

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[1] The question whether the controller is prohibited under federal law from performing Medi-Cal audits or withholding payments to providers is before the United States Court of

HCFA's December 17, 1999, written approval of the DHS's delegation of audit responsibility to the Controller is based on a reasonable construction of the federal statutory single state agency provision and the implementing regulation. We defer to the HCFA's construction of the federal law that it administers as reflected in its action of December 17, 1999. Accordingly, we reverse.

II. FEDERAL MEDICAID LAW

In 1965, Congress enacted Title XIX of the Social Security Act (the Medicaid Act) to provide medical assistance to needy persons. (42 U.S.C. § 1396 et seq.) The purpose of the act was to provide a nationwide program of medical assistance for low-income families and individuals. (*Schweiker v. Hogan* (1982) 457 U.S. 569, 571; *West Virginia University Hospitals, Inc. v. Casey* (3rd Cir. 1989) 885 F.2d 11, 15, affd. (1991) 499 U.S. 83.)

A. The Medi-Cal Program and the Single State Agency Requirement

The Second Circuit Court of Appeals described the joint federal-state operation of the Medicaid program and the single state agency requirement in *Bethphage Lutheran Service, Inc. v. Weicker* (2nd Cir. 1992) 965 F.2d 1239, 1240 as follows: "Medicaid, 42 U.S.C. § 1396 et seq., is a cooperative federal-state program through which the federal government provides financial assistance to the

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Appeals for the Ninth Circuit in several cases including *Simonyan v. Connell* (C.D.Cal. Jan. 20, 2000, No. 99-2420 RJK) 2000 WL 562861.)

states so that the states may furnish medical, rehabilitation, and other services to certain low-income persons. Participation in Medicaid is voluntary, but participating states must comply with certain requirements imposed by the Medicaid Act and regulations promulgated by the Secretary of Health and Human Services ('the Secretary'). For a state to qualify for federal assistance, the Secretary, customarily acting through the Health Care Finance Administration ('HCFA'), must approve a State Plan for medical assistance, 42 U.S.C. § 1396a(a), that contains a comprehensive statement describing the nature and the scope of the state's program. 42 C.F.R. § 430.10 (1989). The plan must designate a single state agency to supervise or administer the State Plan. 42 U.S.C. § 1396a(a)(5)." (Accord, *West Virginia University Hospitals., Inc. v. Casey*, *supra*, 885 F.2d at p. 15.)

1. The Federal Single State Agency Statute

The single state agency requirement is set forth in a federal statute. Pursuant to title 42 of the United States Code, section 1396a(a)(5)[2], a state participating in the federal Medicaid program must establish a state plan that meets stated requirements. Among other things, the state plan must "provide for the establishment or designation of a *single State agency* to administer or to supervise the administration of the plan. . . . "[3] (Italics added.)

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[2] All further references to sections 1396, 1396a, or 1396b, are to title 42 of the United States Code.

[3] Section 1396a (a)(5) states in full: "A State plan for medical assistance must – [¶] . . . [¶] [(a)](5) either provide for the establishment or designation of a single State agency to

The single state agency requirement originally appeared in the Social Security Act of 1935 with reference to the Title I Old-Age Assistance Program. (Stats. 1935, ch. 531, § 2.) The single state agency language was incorporated into Title XIX when the Medicaid program was enacted in 1965. (Pub.L. No. 89-97, 1965 U.S. Code Cong. & Admin. News, at pp. 305, 371; *Sobky v. Smoley* (E.D. Col. 1994) 855 F.Supp. 1123, 1145.) The purposes of the single state agency requirement have been described in various ways. In *Rolland v. Cellucci* (D.Mass. 1999) 52 F.Supp.2d 231, 243, the district court held: "The single state agency mandate arose out of Congress' desire to minimize the improper denial of benefits and to ensure a certain level of services and quality of care. *Morgan v. Cohen*, 665 F.Supp. 1164, 1177 (E.D.Pa. 1987). The mandate accomplishes these goals by limiting the authority to make administrative decisions to a single state agency. 42 C.F.R. § 431.10(e)(1)(ii). . . . . [T]he 'single state agency' requirement derives from a desire to focus accountability for plan operation, *Hillburn by Hillburn v. Maher*, 795 F.2d 252,

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administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter[.]"

261 (2d Cir. 1986); 42 U.S.C. § 1396a(a)(5); 42 C.F.R. §§ 431.1 and 431.10. . . . " In *Sobky v. Smoley, supra,* 855 F.Supp. at page 1145, Judge David F. Levi wrote, "The legislative history of the 1965 Medicaid Act's single state agency requirement – 42 U.S.C. § 1396a(a)(5) – maintains this concentration on administrative efficiency." (Accord *Hillburn v. Maher, supra,* 795 F.2d at pp. 260-261.) Judge Levi concluded after House and Senate amendments were factored into the competing evidence of legislative intent that Congress's adoption of the single state agency was because, "[A]dministrative efficiency appears to have been the overriding purpose. . . . " (*Sobky v. Smoley, supra,* 855 F.Supp. at p. 1146.) In *Fulkerson v. Commissioner, Maine Dept. of Human Services* (D. Maine 1992) 802 F.Supp. 529, 538, the district court held: "It appears that the reason for this requirement was to assure 'that the States will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided' and 'to avoid a lack of accountability for the appropriate operation of the program.' *Hillburn v. Maher[, supra,]* 795 F.2d [at p.] 261[ ] (quoting in part S.Rep. No. 404, 89th Cong., 1st Sess. (1965), reprinted in 1965 U.S. Code Cong. & Admin.News 1943, 2016-17), cert. denied, 479 U.S. 1046, 107 S.Ct. 910, 93 L.Ed.2d 859 (1987)."

2. The Federal Single State Agency Regulation

The HCFA regulation implementing the single state agency requirement is found at title 42, Code of Federal Regulations, part 431.10(e) (44 Fed.Reg. 17930 (March 23, 1979)) which states: "(e) Authority of the single State agency. In order for an agency to qualify as the Medicaid

agency – [¶] (1) The agency must not delegate, to other than its own officials, authority to – [¶] (i) Exercise administrative discretion in the administration or supervision of the plan, or [¶] (ii) Issue policies, rules, and regulations on program matters. [¶] (2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State. [¶] (3) *If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.*" (Italics added; e.g. *Reynolds v. Giuliani* (S.D.N.Y. 2000) 118 F.Supp.2d 352, 358; *Meachem v. Wing* (S.D.N.Y. 1999) 77 F.Supp.2d 431, 444-445.)

The federal single state agency regulation (42 C.F.R. § 431.10(e)) was first published in the Federal Register in 1971. (36 Fed. Regs. 3861-3862 (Feb. 27, 1971).) It was originally promulgated, however, in a supplement to a federal handbook issued upon enactment of the Medicaid Act – the United States Department of Health, Education, and Welfare, Welfare Administration, Bureau of Family Services, *Handbook of Public Assistance Administration* ("Handbook"), Supplement D – Medical Assistance Programs Under Title XIX of the Social Security Act, D 2130 (June 17, 1966) ("Supplement D"). The purpose of the Handbook was described as follows: "The Handbook of Public Assistance Administration is issued by the Bureau of Family Services and is the official medium for issuance

of interpretations and instructions concerning requirements of the public assistance titles of the Social Security Act and recommendations for the administration of State public assistance programs. The Handbook is prepared for use by State agencies and staff of the Federal agency in carrying out their responsibilities for administering the public assistance programs in accordance with the Federal Act." (U.S. Dept. of Health, Education & Welfare, Handbook of Public Assistance Administration, Introduction (June 12, 1963).)

Supplement D stated in part: " . . . [¶] 2. In relationships with other departments of State government, the single State agency interprets its role in such a way that it does not delegate to other than its own officials its requisite ultimate authority for exercising administrative judgment in the State-wide administration or supervision of the plan. [¶] 3. In the event that any rules and regulations or decisions of the single State agency are subject to review, clearance, or other action by other offices or agencies of the State government, the requisite authority of the single State agency is not impaired. [¶] 4. In the event that any services are performed for the single State agency by other State or local agencies or offices, such other agencies or offices are not authorized to, and do not, change, disapprove, or delay action on any administrative decision of the single State agency, or otherwise substitute their judgment for that of the agency as to the application of policies, rules, and regulations promulgated by the State agency. [¶] 5. Any agreements with other public agencies or private organizations to act as the single State agency's agent include provisions for the single State agency obtaining from the agent the data

needed for program planning, evaluation, reporting, and accounting purposes and do not in any way impair the *ultimate authority* of the single State agency. . . . " (U.S. Dept. of Health, Education & Welfare, Handbook of Public Assistance Administration, Supplement D, D-2130, *supra*.)

The foregoing Supplement D provisions were transferred to the Code of Federal Regulations in 1971. (36 Fed. Regs. 3860, 3861-3862.) The 1971 regulation stated in pertinent part: "(c) *Conditions for implementing the requirements of paragraph (a) [state plan requirements] of this section.* (1) The State agency will not delegate to other than its own officials its authority for exercising administrative discretion in the administration or supervision of the plan, including the issuance of policies, rules, and regulations on program matters. [¶] (2) In the event that any rules and regulations or decisions of the single State agency are subject to review, clearance, or other action by other offices or agencies of the State government, the requisite authority of the single State agency will not be impaired. [¶] (3) In the event that any services are preformed [sic] for the single State agency by other State or local agencies or offices, such agencies and offices must not have authority to review, change, or disapprove any administrative decision of the single State agency, or otherwise substitute their judgment for that of the agency as to the application of policies, rules, and regulations promulgated by the State agency." (36 Fed. Regs. 3861-3862 (Feb. 27, 1971.)) The current regulation, quoted above, mirrors the language of both Supplement D and the 1971 regulation without substantive change.

In addition to the above-quoted language ultimately transferred to the Code of Federal Regulations, Supplement D contained a lengthy discussion of the single state agency requirement. There has been no showing that discussion was ever published in the Code of Federal Regulations or the Federal Register. Therefore, that discussion does not rise to the level of a federal rule or regulation carrying the force and effect of law. (*Western Radio Services Co., Inc. v. Espy* (9th Cir. 1996) 79 F.3d 896, 901-902; *St. Nicholas Apartments v. U.S.* (C.D.Ill. 1996) 943 F.Supp. 966, 969; *Rousseau v. City of Philadelphia* (E.D.Pa. 1984) 589 F.Supp. 961, 971; *Usery v. Board of Education* (D.Md. 1978) 462 F.Supp. 535, 548.) Handbooks issued by federal agencies "generally are considered to be non-binding instructions or internal operating procedures." (*Rousseau v. City of Philadelphia, supra,* 589 F.Supp. at p. 971; *U.S. v. Harvey* (5th Cir. 1981) 659 F.2d 62, 65; *Concerned Residents of Buck Hill Falls v. Grant* (3d Cir. 1976) 537 F.2d 29, 38; *St. Nicholas Apartments v. U.S., supra,* 943 F.Supp. at p. 969.) The Handbook has no binding force on this court. (*Burroughs v. Hills* (7th Cir. 1984) 741 F.2d 1525, 1529; *Rank v. Nimmo* (9th Cir. 1982) 677 F.2d 692, 698-699; *U.S. v. Harvey, supra,* 659 F.2d at p. 65.) It is, however, "entitled to notice so far as it is an official interpretation of statutes or regulations with which it is not in conflict." (*Burroughs v. Hills, supra,* 741 F.2d at p. 1529; *Litton Systems, Inc. v. Whirpool* [sic] *Corporation* (Fed.Cir. 1984) 728 F.2d 1423, 1439.) Indeed, the United States Supreme Court has frequently cited to the Handbook as a source of federal agency interpretation of the Medicaid Act and other Social Security Act public assistance programs. (See, e.g., *Lukhard v. Reed* (1987) 481 U.S. 368, 377 [AFDC];

Atkins v. Rivera (1986) 477 U.S. 154, 162 [Medicaid]; *Connecticut Dept. of Income Maintenance v. Heckler* (1985) 471 U.S. 524, 531 fn. 17 [Medicaid]; *Heckler v. Turner* (1985) 470 U.S. 184, 190, fn. 4, 198-199 [AFDC]; *Quern v. Mandley* (1978) 436 U.S. 725, 737 fn. 12 [AFDC].)

In Supplement D, the federal agency interpreted the single state agency requirement as follows: "The requirement for a single State agency means that one State agency is designated by the State as the 'single State agency' and is authorized to maintain in operation for the State an approved State plan. *The State has a choice of administering the plan through the State agency directly or through its political subdivisions under State agency supervision.* [¶] Once the single State agency is established or designated it is the agency of the State government that *represents the State in its dealings with the Federal agency* on all aspects of the medical assistance plan and its operation. It is the agency of the State government responsible for: obtaining the statutory authority necessary to submit a plan meeting all Federal requirements; preparing the State plan and establishing policies for the operation of the program; assuring that it can carry out the plan in all political subdivisions; obtaining the State funds or the State-local funds (as the case may be); meeting all audit requirements; and *being accountable to the [Federal agency] for the proper and efficient administration of the program.* [¶] The provision for a 'single State agency' is not designed to set aside the relationships with the Governor and other officers of the State or with other departments of the State government that are normal and proper within the State. The agency designated as the 'single State agency' is still subject to the ordinary legislative processes, executive

supervision, and budget and audit procedures in the State. *Other agencies and offices of State government, such as the State fiscal officer and the State civil service agency, may perform services for the single State agency that are essential to the operation of the plan. Another agency or authority of government in the State, however, may not be authorized in the plan, or permitted in practice, to substitute its judgment for that of the 'single State agency' in administrative decisions involving the application of the policies, rules, and regulations promulgated by the State agency.* Similarly, if local agencies administer the plan, the 'single State agency' must see that the authority of such agencies to make administrative decisions under the medical assistance law is not impaired by the action of other agencies or officials of State or local governments. [¶] . . . [¶] *The 'single State agency' is responsible for any services that are preformed* [sic] *by other agencies in the program under the plan. This does not mean that the State agency takes over or directs such services. The agency, however, must take such steps as may be necessary in the State to assure that the services, as performed in the medical assistance program, meet the Federal requirements. . . . "* (U.S. Dept. of Health, Education & Welfare, Handbook of Public Assistance Administration, Supplement D – Medical Assistance Programs Under Title XIX of the Social Security Act, D-2140 (June 17, 1966), italics added.)

B. The State Plan

A state must submit to the HCFA for approval a plan describing the nature and scope of its Medicaid program and establishing, among other things, a plan for reimbursing providers. (§ 1396a(a); 42 C.F.R. § 430.10; *Wilder v. Virginia Hosp. Assn.* (1990) 496 U.S. 498, 502; *Children's*

Hospital and Health Center v. Belshe (9th Cir. 1999) 188 F.3d 1090, 1098.) The state plan also must provide for postpayment review of provider claims. (§ 1396a(a)(37); 42 C.F.R. §§ 447.45(c)(1) & (f)(2), 456.3.) The HCFA is authorized to make payments to states whose medical assistance plans meet the requirements of the federal statute. (§ 1396; *Morris v. Williams* (1967) 67 Cal.2d 733, 738-739; *Palumbo v. Myers* (1983) 149 Cal.App.3d 1020, 1025, 197 Cal.Rptr. 214.) Judge Levi has succinctly held: "The [HCFA's] approval of the State plan is a necessary precondition to the State's entitlement to federal funds. (. . . §§ 1396, 1396b(a).)" (*Exeter Memorial Hospital Assn. v. Belshe* (E.D.Cal. 1996) 943 F.Supp. 1239, 1240, affd. (9th Cir. 1998) 145 F.3d 1106, 1109.) As the California Supreme Court observed in *Reese v. Kizer* (1988) 46 Cal.3d 996, 998, "To assure the continued availability of federal funds for these programs[, including Medi-Cal,] the state must operate plans which conform to the governing federal statutes and regulations." Under HCFA regulations, amendments to state plans must conform to the following regime: "The plan must provide that it will be amended whenever necessary to reflect – [¶] (i) Changes in Federal law, regulations[,] policy interpretations, or court decisions; or [¶] (ii) Material changes in State law, organization, or policy, or in the State's operation of the Medicaid program. . . . " (42 C.F.R. § 430.12(c).) HCFA regional staff review state plans and plan amendments. (42 C.F.R. § 430.14.) The HCFA Regional Administrator has the authority to approve state plans and plan amendments. (42 C.F.R. § 430.15(b).) Pursuant to title 42 of the Code of Federal Regulations, part 430.15(a)(1), "Determinations as to whether State plans (including plan amendments and

administrative practice under plans) originally meet or continue to meet the requirements for approval are based on relevant Federal statutes and regulations."

III. BACKGROUND

The underlying facts are undisputed. California submitted its state Medicaid plan to the HCFA in 1993. The state plan identified the DHS as the single state Medicaid agency for all purposes including auditing payments to providers.

On July 1, 1997, the DHS and the Controller entered into an interagency agreement "for the purpose of increasing the State's auditing ability to identify and recover California Medical Assistance Program (Medi-Cal Program) overpayments. . . . " The interagency agreement authorized the Controller "to perform audit services relating to the Medi-Cal Program," including, in the event of an overpayment, to send a repayment demand to the provider together with a copy of the audit report. The Controller was *not* authorized *as DHS's representative* to withhold payments to providers. However, if the Controller initiated a withhold "under its own [state law] authority," it was required to notify the DHS.[4]

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[4] The Interagency Agreement set forth the Controller's responsibilities as follows: "1. [The Controller] will perform audit services relating to the Medi-Cal Program. . . . These services will include audits as detailed in the Scope of Work designed to identify overpayments made under the Medi-Cal Program to providers. [¶] 2. The [Controller] will notify DHS Audits & Investigations prior to onsite reviews of Medi-Cal providers. This will reduce duplication of effort by both

Acting under the interagency agreement, the Controller conducted a review of RCJ's Medi-Cal claims for the

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agencies. [¶] 3. [The Controller's] audits will be finalized in audit reports and draft audit reports will be submitted to the [DHS] at least 15 days prior to issuance. [¶] 4. If the audit identifies an overpayment of Medi-Cal funds, a demand for repayment will be sent to the provider with a copy of the audit report. The demand will provide information to the provider regarding appeal rights. Copies of the audit report and demand for repayment shall be sent to Audits & Investigations and the DHS Office of Administrative Hearings & Appeals. [¶] 5. As a representative of DHS, [the Controller] will not initiate a withhold of a provider's reimbursement in the amount identified by the audit. [¶] 6. However, if [the Controller] initiates a withhold under its own authority, [the Controller] will not issue notices of withhold with the audit report and demand notice. Also, [the Controller] will notify DHS when it initiates payment withholds for Medi-Cal providers. This will facilitate DHS's ability to track Medi-Cal reimbursement disposition and to respond to provider inquiries concerning payment. [¶] 7. [The Controller] will be responsible for the resolution of the audit findings identified in their audits, through and including the administrative appeal process before DHS Office of Administrative Hearings and Appeals (OAHA) under Welfare and Institutions Code section 14171, including legal representation if needed. [¶] 8. [The Controller] will designate the following state member as [the Controller's] contact person for purposes of this agreement:. . . . "

Exhibit A to the Interagency Agreement entitled "Scope of Work" stated: "A. [The Controller] will target its audits for the following program issues using trend analysis based on Medi-Cal expenditures and historical patterns: [¶] 1. Some non-institutional providers with high volume of selected products engage in unlawful or excessive practices; [¶] 2. Some non-institutional providers with high volume of selected products are incorrectly billing for products or services that should be billed at a lesser reimbursement rate; [¶] 3. Some Pharmacy and DME providers are billing Medi-Cal for unsupported quantities

period from January 9, 1997, to October 9, 1997, and a subsequent review for the period from October 10, 1997, to March 26, 1998. The Controller issued final audit *overpayment* findings in reports dated March 10, 1998, and May 4, 1998. RCJ requested an administrative appeal.

On July 1, 1998, the DHS and the Controller entered into an amended interagency agreement. Under the amended interagency agreement, the Controller retained authority to audit Medi-Cal claims by providers and to send repayment demands. However, with respect to the power to *withhold* payments from a provider, the July 1, 1998, amended interagency agreement provided, "Only DHS may initiate a withhold of a provider's Medi-Cal funds during a review, audit, or investigation." The present case involves only an overpayment determination. The Controller did not withhold any funds from RCJ.

On February 1, 1999, Division Seven of the-Court of Appeal for this appellate district issued its opinion in *Doctor's Medical Laboratory, Inc. v. Connell* (1999) 69

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of products; and/or, [¶] 4. Some non-institutional providers are reimbursed improperly and recovery is warranted under title 22, California Code of Regulations, section 51458.1 [¶] B. In performing audits for DHS, [the Controller] will document their results in audit reports. [The Controller] will collect and retain sufficient evidence to substantiate all audit findings and recommendations. [¶] C. The [Controller] will ensure that audit reports are clear, accurate, and meet all of the statutory and regulatory requirements of an audit of Medi-Cal Providers. At a minimum, the audit reports will include a description of the scope of the audit, a reference to Medi-Cal authority, and the methodology used. [¶] D. Specifically, [the Controller] will abide by the following: [specified Welfare and Institutions Code sections and California regulations]."

Cal.App.4th 891, 896-898. In *Doctor's*, the Controller withheld payments to a provider. Our Division Seven colleagues held the Controller could not lawfully exercise the power to audit or to withhold Medi-Cal payments to providers. (*Ibid.*) The California Supreme Court denied review. The remittitur issued on May 26, 1999.

By letter dated March 19, 1999, after the *Doctor's* decision was filed, the DHS asked the HCFA to review the July 1, 1998, amended interagency agreement and to "confirm our opinion about the allowability of the [interagency agreement] activities under the Medicaid program." By letter dated on or about March 24, 1999, Sally Richardson, Director, Center for Medicaid and State Operations, HCFA, responded to the DHS's request. Ms. Richardson's letter, written on behalf of the HCFA, concluded that the amended interagency agreement was "fully compliant with federal single State agency requirements." Further, Ms. Richardson concluded, "[W]e see nothing in [the Interagency Agreement] that gives [the Controller] discretionary authority that would violate the single State agency requirements at 42 CFR 431.10."[5]

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[5] Ms. Richardson's letter states in full: "I am writing in response to your March 19 letter concerning the interagency agreement (IA) between the [DHS] and the [Controller] under which the [Controller] conducts audits of Medi-Cal payments to providers. You enclosed a copy of that IA, and asked that we advise whether the specific [Controller] functions performed under it in fact are consistent with DHS' responsibilities as California's single State agency for purposes of Medicaid program administration. [¶] The Medicaid program's single State agency requirements are found in section 1902(a)(5) of the Social Security Act, and at 42 CFR 431.10. The requirement that each State designate a single State agency to administer or

On April 1, 1999, an administrative law judge issued a proposed decision in RCJ's appeal. On June 7, 1999, the

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supervise the administration of the program dates to enactment of the Social Security Act in 1935, where it appears with reference to the Title I Old-Age Assistance Program. The same wording was incorporated into Title XIX when the Medicaid program was enacted in 1965. The intent in both instances was to ensure that there be a single agency in each State accountable to the federal government for administration of the program in compliance with federal law and policy. [¶] Regulations at 42 CFR 431.10 require that: '. . . . ' [quoting the regulation] [¶] California's approved Title XIX State Plan designates the DHS as the single State agency responsible for administering that Plan. The DHS organization chart vests responsibility for fraud and abuse, internal and external audits, and quality control in the Audits and Investigations Division. The Chief of the Medical Review Branch, Audits and Investigations, is the DHS contact point for purposes of the subject IA. Under the IA, the [Controller] is to perform audits on behalf of DHS to identify overpayments made to providers under the Medi-Cal program. The Scope of Work states that the IA is 'for the purpose of increasing the State's auditing ability to identify and recover California Medical Assistance Program (Medi-Cal Program) overpayments and to provide federal matching funds for [the Controller] audit services to the Medi-Cal Program.' The [Controller] must notify DHS Audits and Investigations when it initiates a review, audit or investigation of a Medi-Cal provider. If the [Controller] identifies an overpayment, it is to write the provider describing the overpayment, request repayment, and describe the provider's administrative appeal rights. We understand that such letters instruct the provider to either make payment to the DHS Payment Systems Division, Recovery Section for repayment purposes, if the provider agrees with the overpayment determination or, in the event the provider disagrees with the [Controller's] determination, file an appeal with the DHS Office of Administrative Hearings and Appeals. The IA requires the [Controller] to transmit to DHS Audits and Investigations a copy of each audit report and demand letter,

DHS rejected the proposed decision. On August 5, 1999, following a review of the administrative record, the DHS issued its final decision. On October 28, 1999, RCJ filed its writ petition in the trial court.

On December 17, 1999, the DHS submitted a state plan amendment to the HCFA. The amended state plan provided in relevant part, "The State Controller's Office will perform audits of Medi-Cal expenditures on behalf of DHS and will submit its findings and recommendations to DHS for appropriate action." The DHS requested

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and make all related working papers available to DHS for review upon request. In addition, the IA specifies that the [Controller] will make referrals only to Audits and Investigations, and not directly to DHS Recovery, DHS Office of Administrative Hearings and Appeals, or any law enforcement or other agency. [¶] With respect to the fraud referral process, the IA specifies that the [Controller] may recommend to the DHS that it initiate a withhold action when the [Controller] 'collects evidence of potential fraud or willful misrepresentation during an investigation' (Scope of Work, paragraph 10). Federal regulations at 42 CFR 455.23 authorize such withholds by the State Medicaid agency. The IA stipulates that the [Controller] will not make independent fraud referrals to law enforcement agencies, and that DHS will exercise its discretion as the Medicaid single State agency when making such referrals. [¶] Based upon our review of the IA, the pertinent section of the California State Plan, and the applicable federal regulations, we conclude that the IA is fully compliant with federal single State agency requirements. The fact that DHS vests Medi-Cal audit functions in Audits and Investigations does not preclude DHS from augmenting its own audit resources through an appropriate arrangement with the [Controller]. The IA itself states that 'DHS will exercise its authority as the Medicaid single state agency,' and we see nothing in it that gives the [Controller] discretionary authority that would violate the single State agency requirements at 42 CFR 431.10."

an effective date of July 1, 1998. Also on December 17, 1999, the HCFA approved the state plan amendment with an effective date of July 1, 1998, as requested. The HCFA's letter signed by Karen Fuller, stated in relevant part: "[The state plan amendment] amends the State plan to reflect the fact that the State Controller's Office performs audits of Medi-Cal expenditures on behalf of the Department of Health Services (DHS). [¶] Our review of [the state plan amendment] was conducted in accordance with the requirements of section 1902(a)(5) of the Social Security Act (the Act) and the regulatory provisions at 42 CFR 431.10 and 431.11."

On May 19, 2000, the trial court issued the peremptory writ of mandate in this case. As noted above, the court directed the DHS to set aside its final decision in RCJ's administrative appeal "insofar as it relies upon the audit findings of the State Controller. . . . "

IV. DISCUSSION

A. Private Right of Action

The DHS contends RCJ has no "private right of action" to enforce the single state agency requirement embodied in the federal statute (§ 1396a(a)(5)) and its implementing regulation (42 C.F.R. § 431.10(e)). The DHS discusses federal decisional authority concerning whether a health care provider may bring an action under title 42 of the United States Code, section 1983, to challenge state practices under the Medicaid Act. (See *Wilder v. Virginia Hospital Assn., supra,* 496 U.S. at p. 501; *Sobky v. Smoley, supra,* 855 F.Supp. at pp. 1130-1133.) Those decisions are inapposite. RCJ does not seek to enforce a

private right of action under title 42 of the United States Code, section 1983, or otherwise. Rather, RCJ seeks judicial review of a final administrative decision arising from a Medi-Cal audit pursuant to Code of Civil Procedure section 1094.5. Welfare and Institutions Code section 14171, subdivision (j), specifically authorizes such review.[6] RCJ's writ of mandate pursuant to Code of Civil Procedure section 1094.5 is the proper means by which a Medi-Cal provider may challenge an individual audit decision. (Welf. & Inst.Code, § 14171, subdivision (j); *Florence Western Medical Clinic v. Bontá* (2000) 77 Cal.App.4th 493, 502-503, fn. 8; *Frankel v. Kizer* (1993) 21 Cal.App.4th 743, 750.) The DHS does *not* contend the issue presented here is beyond the scope of the issues that may be raised upon judicial review pursuant to Welfare and Institutions Code section 14171, subdivision (j).

B. *Doctor's Medical Laboratory, Inc. v. Connell* Is Not Controlling

RCJ, by its writ petition, sought to set aside the DHS's final decision in this case, as "refusing to abide by" the Court of Appeal decision in *Doctor's Medical Laboratory, Inc. v. Connell, supra,* 69 Cal.App.4th at pages

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[6] Welfare and Institutions Code section 14171 provides in pertinent part: "(a) The director shall establish administrative appeal processes to review grievances or complaints arising from the findings of an audit. . . . [¶] . . . [¶] (j) The final decision of the director shall be reviewable in accordance with Section 1094.5 of the Code of Civil Procedure within six months of the issuance of the director's final decision."

896-898, 81 Cal.Rptr.2d 829 (*Doctor's*). RCJ contends Doctor's controls the resolution of this case. We respectfully disagree. In *Doctor's*, a Medi-Cal provider sought a writ of mandate to compel the Controller to release approximately $3 million in payments that had been withheld. (*Doctor's, supra,* 69 Cal.App.4th at p. 893.) The provider alleged the Controller's refusal to pay the claims had led to its insolvency. (*Id.* at p. 895.) The Court of Appeal found the 1997 Interagency Agreement improperly authorized the Controller "to perform audits to identify overpayments to providers, and to take corrective action, presumably withholding sums believed to constitute overpayment." (*Id.* at p. 895.)

We need not address the DHS's disagreement with our Division Seven colleagues' conclusions. The *Doctor's* opinion was filed on February 1, 1999. On March 24, 1999, the HCFA, by process of Ms. Richardson's letter, expressed approval of the Controller's audit authority. On December 17, 1999, well after the *Doctor's* opinion was filed, the HCFA approved the use of the Controller as the audit agency effective July 1, 1998. In *Doctor's*, the Court of Appeal did not confront, nor could our Division Seven colleagues have confronted, the subsequent December 17, 1999, federal agency approval of the Controller's contractual authority to audit Medi-Cal payments to providers. The December 17, 1999, HCFA approval happened entirely after the *Doctor's* opinion was filed. The HCFA's approval of the delegated audit authority is squarely presented in this case. Moreover, as discussed below, we conclude we must defer to the HCFA's construction of the federal statutory and regulatory law that it administers as reflected in its December 17, 1999, action.

RCJ contends the HCFA's action is immaterial because the Controller audited it *before* the HCFA expressed its approval. We disagree. By its writ petition, RCJ sought to set aside the DHS's final decision because it relied on the Controller's audit. At the time the DHS issued its final decision, the HCFA had by letter expressed its opinion that the delegation of audit authority to the Controller was fully compliant with federal single state agency requirements. Moreover, at the time the trial court issued its order directing the DHS to set aside its final decision to the extent it relied on the Controller's audit, the HCFA had in addition approved the state plan amendment effective July 1, 1998. Under these circumstances, we conclude, the federal agency's interpretation of its own regulation was squarely presented.

C. The HCFA's Construction of the Federal Law that it Administers is Entitled to Deference

1. Congress has not Specifically Addressed the Precise Question at Issue

RCJ does not specifically contend nor do we conclude that the HCFA's regulation is an impermissible construction of the federal statutory single state agency requirement. RCJ asserts in general terms that the language of the federal statute and regulation is clear, unambiguous, and mandatory. RCJ contends the plain language and "obvious" meaning of the federal statute (§ 1396a(a)(5)) and the implementing regulation (42 C.F.R. § 431.10(e)) prohibit the DHS from delegating audit authority to the Controller; further, the HCFA's conclusion to the contrary

contradicts the federal law and therefore is not entitled to any deference. We disagree.

The United States Supreme Court explained the standard to be applied on review of an administrative agency's construction of a statute which it administers in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.* (1984) 467 U.S. 837, 842-845: "When a court reviews an agency's construction of [a] statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. *Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.* [Fn. 9.] . . . . [¶] 'The power of an administrative agency to administer a congressionally created . . . program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress.' [Citation.] If Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation. Such legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute. Sometimes, the legislative delegation to an agency on a particular

question is implicit rather than explicit. In such a case, a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency. [¶] We have long recognized that considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer, and the principle of deference to administrative interpretations 'has been consistently followed by this Court whenever decision as to the meaning or reach of a statute has involved reconciling conflicting policies, and a full understanding of the force of the statutory policy in the given situation has depended upon more than ordinary knowledge respecting the matters subjected to agency regulations.' [Citations.] ' . . . If this choice represents a reasonable accommodation of conflicting policies that were committed to the agency's care by the statute, we should not disturb it unless it appears from the statute or legislative history that the accommodation is not one that Congress would have sanctioned.' [Citation.]" (Fns. omitted, italics added; accord, *Garfield Medical Center v. Belshé* (1998) 68 Cal.App.4th 798, 807-808.) Simply stated, once a court determines, after reviewing the legislation, that Congress did not directly address the precise question at issue, the pertinent question is whether the administrative construction in the form of a regulation is reasonable. (*Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., supra,* 467 U.S. at p. 845; accord, *Alexander v. Sandoval* (2001) ___ U.S. ___, ___ [121 S.Ct. 1511, 1518].) As the United States Supreme Court further held in *Chevron U.S.A., Inc.*, "The court need not conclude that the agency construction was the only one it permissibly could have

adopted to uphold the construction, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding. [Citations.]" (*Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., supra,* 467 U.S. at p. 843, fn. 11; *Zenith Radio Corp. v. United States* (1978) 437 U.S. 443, 450.)

We consider the language of the federal statute. We find Congress has not directly addressed the precise question at issue; however, the statutory language plainly suggests that a state Medicaid agency may delegate functions to another state agency. Because we are considering a federal statute, we follow rules of statutory construction enunciated by the United States Supreme Court. In *Kaiser Aluminum & Chemical Corp. v. Bonjorno* (1990) 494 U.S. 827, 835, quoting from *Consumer Product Safety Comm'n v. GTE Sylvania* (1980) 447 U.S. 102, 108, the United States Supreme Court held: "The starting point for interpretation of a statute 'is the language of the statute itself. Absent a clearly expressed legislative intention to the contrary, that language must ordinarily be regarded as conclusive.' " The United States Supreme Court has noted that "the statutory language controls its construction" (*Ford Motor Credit Co. v. Cenance* (1981) 452 U.S. 155, 158, fn. 3) and that " '[t]here is, of course, no more persuasive evidence of the purpose of a statute than the words by which the [L]egislature undertook to give expression to its wishes.' " (*Griffin v. Oceanic Contractors, Inc.* (1982) 458 U.S. 564, 571.) In interpreting a statute, the United States Supreme Court has noted: " 'In expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.' [Citations.] Our

objective in a case such as this is to ascertain the congressional intent and give effect to the legislative will." (*Philbrook v. Glodgett* (1975) 421 U.S. 707, 713.) On another occasion, the court stated, "We do not, however, construe statutory phrases in isolation; we read statutes as a whole." (*United States v. Morton* (1984) 467 U.S. 822, 828, fn. omitted.) Further, in interpreting a statute, the Supreme Court has emphasized the importance of avoiding: "absurd results" (*United States v. Turkette* (1981) 452 U.S. 576, 580); " 'an odd result' " (*Public Citizen v. U.S. Department of Justice* (1989) 491 U.S. 440, 454); or " unreasonable results whenever possible." (*American Tobacco Co. v. Patterson* (1982) 456 U.S. 63, 71.) Moreover, the Supreme Court has noted, "Judicial perception that a particular result would be unreasonable may enter into the construction of ambiguous provisions, but cannot justify disregard of what Congress has plainly and intentionally provided." (*Commissioner of the Internal Revenue v. Asphalt Products Co., Inc.* (1987) 482 U.S. 117, 121.) In *Griffin v. Oceanic Contractors, Inc., supra,* 458 U.S. at p. 571, the court stated: "Nevertheless, in rare cases the literal application of a statute will produce a result demonstrably at odds with the intentions of its drafters, and those intentions must be controlling. . . . [Citations.]" When a statute is unambiguous, its language cannot "be expanded or contracted by the statements of individual legislators or committees during the course of the [legislative] process." (*West Virginia Univ. Hospitals, Inc. v. Casey, supra,* 499 U.S. at pp. 98-99.)

As noted above, section 1396a(a)(5) requires that a state Medicaid plan "provide for the establishment or designation of a single State agency *to administer or to*

supervise the administration of the plan. . . . " It is clear the federal statute does not specifically address the question whether a state Medicaid agency can delegate audit responsibility to another state agency. It does expressly provide, however, that the designated single state agency will *administer or supervise* the administration of the state plan. The use of the disjunctive means the terms "administer" and "supervise" must be given separate meanings except where the context dictates otherwise. (*Reiter v. Sonotone Corp.* (1979) 442 U.S. 330, 339; *F.C.C. v. Pacifica Foundation* (1978) 438 U.S. 726, 739-740.) To "administer" means "to manage the affairs of" the state Medicaid program. (Oxford English Dict. (2d ed. CD-ROM 1994).) To "supervise" means "[t]o oversee," "to have the oversight of, superintend the execution or performance of (a thing). . . . " (*Ibid.*) Here, under the plain language of section 1396a(a)(5), the DHS is authorized to *supervise* the administration of the state Medicaid program; that is, to oversee the execution or performance of the program. The federal statute's use of the word "supervise," which means something other than administer, plainly suggests that entities other than the single state agency may be involved in the administration of the program under the Medicaid agency's supervision. Further, as discussed above, the legislative purpose of the single state agency requirement was both to avoid a diversity of operating standards within a state and to ensure that one agency would be accountable to the federal government for the operation of Medicaid program and compliance with federal law. (*Sobky v. Smoley, supra,* 855 F.Supp. at pp. 1145-1146; *Hillburn v. Maher, supra,* 795 F.2d at p. 261.) The language of section 1396a(a)(5) is consistent with that

purpose; it requires a Medicaid agency to administer or supervise the administration of the state program (§ 1396a(a)(5)), thereby ensuring consistent operating standards and accountability to the federal government. We conclude, therefore, that although Congress did not speak to the precise question at issue in this case, the statutory language does plainly suggest that a state Medicaid agency may delegate functions to another state agency. As the United States District Court for the District of Rhode Island held in *King v. Sullivan* (1991) 776 F.Supp. 645, 656-657, "Section 1396a(a)(5) requires that a State Plan provide for a single state agency 'to administer *or to supervise the administration of* the plan.' 42 U.S.C. § 1396a(a)(5) (1988) (emphasis added). The statute does not require states to use only one agency to carry out every task that is part of the State Plan. *See* 42 C.F.R. § 431.10(e)(3) (1990). . . . "

2. The HCFA's Regulation is a Permissible Construction of the Federal Statute

We turn to the HCFA's implementing regulation. As discussed above, where, as here, Congress has not directly addressed the precise issue, the question for a state court is whether the federal agency's answer is based on a permissible construction of the statute. (*United States v. Morton, supra,* 467 U.S. at p. 834; *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., supra,* 467 U.S. at p. 843.) We conclude the implementing regulation is a permissible construction of the federal statute.

As noted above, the HCFA interpreted the federal statutory single state agency requirement in title 42 of the

Code of Federal Regulations, part 431.10 as follows: "(e) Authority of the single State agency. In order for an agency to qualify as the Medicaid agency – [¶] (1) The agency must not delegate, to other than its own officials, authority to – [¶] (i) Exercise administrative discretion in the administration or supervision of the plan, or [¶] (ii) Issue policies, rules, and regulations on program matters. [¶] (2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State. [¶] (3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency." The HCFA's regulation is consistent with both the language and legislative purpose of the federal statute. The implementing regulation requires that the state Medicaid agency retain, and not delegate, *its* ultimate authority to *"[e]xercise administrative discretion in the administration* or *supervision of the [state] plan."* (42 C.F.R. § 431.10(e)(1)(i), italics added.) It further requires that the state Medicaid agency retain, and not delegate, it [sic] authority to "[i]ssue policies, rules, and regulations on program matters." (42 C.F.R. § 431.10(e)(1)(ii).) Under the regulation, if another entity performs services for a single Medicaid agency, it "must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute [its] judgment for that of the Medicaid agency with respect to the application of policies, rules, and

regulations issued by the Medicaid agency." (42 C.F.R. § 431.10(e)(3).). The regulation ensures that the single state agency will retain administrative discretion in the supervision of the Medicaid program and will remain accountable to the government of the United States for the state's administration of the program and compliance with federal Medicaid law. We conclude the HCFA's construction of the federal statutory single state agency requirement in title 42 of the Code of Federal Regulations, part 430.10(e), is a permissible and reasonable one.

3. Application of the Regulation to the Circumstances of this Case was not Plainly Erroneous or Inconsistent with the Regulation

RCJ contends that the HCFA's application of its own regulation to the circumstances of this case is plainly erroneous or its reasoning is inconsistent with the regulation. We disagree.

The United States Supreme Court has held that a federal agency's interpretation of its own regulation is controlling unless it is " 'plainly erroneous or inconsistent with the regulation.' " (*Robertson v. Methow Valley Citizens Council* (1989) 490 U.S. 332, 359, quoting *Bowles v. Seminole Rock & Sand Co.* (1945) 325 U.S. 410, 414; *Auer v. Robbins* (1997) 519 U.S. 452, 461; *Martin v. Occupational Safety and Health Review Com.* (1991) 499 U.S. 144, 150-151; *Udall v. Tallman* (1965) 380 U.S. 1, 16.) To paraphrase the Supreme Court in a case involving the Department of Health and Human Services: "[W]e must defer to the [HCFA's] interpretation [of its own regulation] unless an 'alternative reading is compelled by the regulation's plain

language or by other indications of the [HCFA's] intent at the time of the regulation's promulgation.' [Citation.]" (*Thomas Jefferson University v. Shalala* (1994) 512 U.S. 504, 512; *Christensen v. Harris County* (2000) 529 U.S. 576, 588 [deference to agency's interpretation of regulation unwarranted where interpretation contradicted plain and clear language of regulation].)[7] The lower federal courts have held the HCFA's interpretation of Medicaid regulations is entitled to great weight and deference. (*New York Dept. of Social Services v. Dublino* (1973) 413 U.S. 405, 421; *Visiting Nurse Association of North Shore, Inc. v. Bullen* (1st Cir. 1996) 93 F.3d 997, 1002; *North Carolina v. United States Dept. of Health and Human Servs.* (4th Cir. 1993) 999 F.2d 767, 769-770; *Folden v. Washington State Dept. of Social and Health Servs.* (9th Cir. 1992) 981 F.2d 1054, 1058; *Missouri Dept. of Social Servs. v. Sullivan* (8th Cir. 1992) 957 F.2d 542, 544; *Citizens Action League v. Kizer* (9th Cir. 1989) 887 F.2d 1003, 1007; *Garfield Medical Center v. Belshé, supra*, 68 Cal.App.4th at p. 808; *Dept. of Health Services v. Superior Court* (1991) 232 Cal.App.3d 776, 782; *Frank v. Kizer* (1989) 213 Cal.App.3d 919, 924; see *Eisenberg v. Myers* (1983) 148 Cal.App.3d 814, 822.) As the United States Court of Appeal for the Seventh Circuit held in *Indiana Assn. of Homes for the Aging Inc. v. Indiana Office of Medicaid Policy and Planning* (7th Cir. 1995) 60 F.3d 262, 266, the HCFA's interpretation of its own regulations "is of controlling

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[7] The United States Supreme Court's recent decision in *United States v. Mead Corporation* (2001) ___ U.S. ___, ___ [121 S.Ct. 2164, 2170] does not change this standard of review. *Mead Corporation* involved a tariff classification by the United States Customs Service. No federal agency interpretation of its own regulation was at issue in *Mead Corporation*.

weight unless plainly erroneous or inconsistent with the regulation." As the United States Court of Appeals for the First Circuit explained in *Visiting Nurse Association of North Shore, Inc. v. Bullen, supra,* 93 F.3d at page 1002: "As a federal agency charged with administering the Medicaid program . . . HCFA plainly is entitled to [*Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., supra,* 467 U.S. at pp. 842-843] deference in its interpretations of the [Medicaid] Act and the implementing regulations. [Citations.] Indeed, when a federal agency has promulgated and published a regulation pursuant to its own enabling statute, we review its interpretation of that *regulation* under a standard even 'more deferential . . . than that afforded under *Chevron*' to the agency's interpretation of the Statute. [Citations.] '[P]rovided an agency's interpretation of its own regulation does not violate the Constitution or a federal statute, it must be given "controlling weight unless it is *plainly erroneous* or inconsistent with the regulation." ' [Citations.]"

RCJ does not specifically challenge the December 17, 1999, state plan amendment. However, that under federal law, when, as here, a state plan or amendment has been reviewed and approved by the HCFA, a party challenging its legality must show that the provisions at issue are " 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law' before [a court] will find them substantively invalid." (*Concourse Rehabilitation & Nursing Center, Inc. v. DeBuono* (1999) 179 F.3d 38, 44; *Pinnacle Nursing Home v. Axelrod* (2d Cir. 1991) 928 F.2d 1306, 1313; *California Hospital Assn. v. Schweiker* (C.D. Cal. 1982) 559 F.Supp. 110, 116.) In *Indiana Assn. of Homes for*

the Aging Inc. v. Indiana Office of Medicaid Policy and Planning, supra, 60 F.3d at page 266, the United States Court of Appeals for the Seventh Circuit held: "Indiana's amended [Medicaid] plan was approved by HCFA and is accordingly a product of state and federal agency action. [Citation.] 'A trial court, therefore, must review the plan with the deference accorded federal agency actions.' [Citations.] 'This deference entitles the . . . plan to a presumption of regularity, but does not prevent the court from a thorough, probing, in-depth review.' [Citations.] In conducting this review, the court 'shall hold unlawful and set aside agency action, findings and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law' or 'without observance of procedure required by law.' " [Citation.]" 'Our state courts have recognized that the HCFA's approval of California's Medicaid plan is entitled to deference unless "palpably erroneous." (*Garfield Medical Center v. Belshe, supra,* 68 Cal.App.4th at p. 808; *Eisenberg v. Myers, supra,* 148 Cal.App.3d at p. 822.)

We find the HCFA's construction of its own regulation as reflected in Ms. Richardson's March 24, 1999, letter and the December 17, 1999, approval of the state plan amendment as allowing the DHS to delegate audit responsibility to the Controller is entitled to deference. RCJ contends the single state agency regulation (42 C.F.R. § 431.10(e)(3)) specifically prohibits the DHS from delegating *any* administrative discretion to another state agency *unless* expressly authorized to do so by another regulation as, for example, with respect to eligibility

determinations (42 C.F.R. § 431.10(c)).[8] We disagree. The HCFA has, from the inception of Medicaid until the present time, interpreted the regulation at issue as allowing a single state Medicaid agency to delegate responsibilities to another state agency. The HCFA has permitted such delegation so long as the single state Medicaid agency: supervises the other agency; remains responsible for that agency's actions; and remains accountable to the federal government for the administration of the state Medicaid plan. (U.S. Dept. of Health, Education & Welfare, Handbook of Public Assistance Administration, Supplement D – Medical Assistance Programs Under Title XIX of the

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[8] Title 42, Code of Federal Regulations, part 431.10(c) states: "Determination of eligibility. [¶] (1) The plan must specify whether the agency that determines eligibility for families and for individuals under 21 is – [¶] (i) The Medicaid agency; or [¶] (ii) The single State agency for the financial assistance program under title IV-A (in the 50 States or the District of Columbia), or under title I or XVI (AABD), in Guam, Puerto Rico, or the Virgin Islands. [¶] (2) The plan must specify whether the agency that determines eligibility for the aged, blind, or disabled is – [¶] (i) The Medicaid agency; [¶] (ii) The single State agency for the financial assistance program under title IV-A (in the 50 States or the District of Columbia) or under title I or XVI (AABD), in Guam, Puerto Rico, or the Virgin Islands; or [¶] (iii) The Federal agency administering the supplemental security income program under title XVI (SSI). In this case, the plan must also specify whether the Medicaid agency or the title IV-A agency determines eligibility for any groups whose eligibility is not determined by the Federal agency. [¶] (d) Agreement with Federal or State agencies. The plan must provide for written agreements between the Medicaid agency and the Federal or other State agencies that determine eligibility for Medicaid, stating the relationships and respective responsibilities of the agencies."

Social Security Act, D 2140 (June 17, 1966).) In the HCFA's view, a regulation expressly authorizing a state Medicaid agency to delegate *audit* authority to another state agency is not required. As noted above, the current single state agency regulation (42 C.F.R. § 431.10(e)) states that the state Medicaid agency may rely on other state agencies' services provided that it does not delegate *its* authority, i.e., its ultimate authority: to "[e]xercise administrative discretion in the administration or supervision of the plan"; or to "[i]ssue policies, rules, and regulations on program matters." (42 C.F.R. § 431.10(e)(1)(i) & (e)(1)(ii)). In addition, title 42, Code of Federal Regulations part 431.10(e)(2) states, "The authority of the [state Medicaid] agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State." Another state entity performing services for the state Medicaid agency must not have the authority: "to change or disapprove" the state Medicaid agency's administrative decisions. (42 C.F.R. § 431.10(e)(3).) Further, the other entity must not have the authority to substitute its judgment for that of the state Medicaid agency "with respect to the application of policies, rules, and regulations issued by the Medicaid agency." (*Ibid.*)

Moreover, it is undisputed the DHS has not delegated to the Controller any authority to issue policies, rules, or regulations on Medi-Cal program matters. Nor do we find that the Controller reviews or takes similar action with respect to the DHS's rules, regulations, or decisions. Further, RCJ has not pointed to, and we have not found, *any* evidence in the record that the Controller has been given authority to change or disapprove any

administrative decision by the DHS. Instead, the Controller undertakes, on DHS's behalf, required postpayment reviews of provider claims. RCJ also has not pointed to, and we have not found, *any* evidence in the record that the Controller's office has the authority to substitute its judgment for that of the DHS with respect to the application of policies, rules, and regulations issued by the DHS. Nor has the DHS delegated to the Controller any authority to exercise discretion in the administration or supervision of the statewide Medicaid plan. The interagency agreement does not have any bearing on the ultimate authority of the DHS to exercise administrative judgment in the statewide administration or supervision of the Medi-Cal program as conducted under the state plan. What the DHS *has* delegated to the Controller is only the authority to conduct postpayment audits of Medi-Cal provider claims. The DHS has authorized the Controller to: perform audit services including audits designed to identify overpayments to providers; "target its audits for [specified] program issues using trend analysis based on Medi-Cal expenditures and historical patterns"; document results in "clear, accurate" audit reports meeting "all of the statutory and regulatory requirements of an audit of Medi-Cal providers"; abide by specified state codes and regulations; "collect and retain sufficient evidence to substantiate all audit findings and recommendations"; issue repayment demands; send repayment demands to providers with a copy of the audit report; provide information to the provider regarding appeal rights; and take responsibility for the resolution of audit findings through and including the administrative appeal process. The DHS remains ultimately responsible for

postpayment audits of Medi-Cal providers. The DHS supervises the Controller's services. The Controller must notify the DHS's Audits and Investigations Division "prior to onsite reviews of Medi-Cal providers." The Controller must provide draft audit reports to the DHS at least 15 days prior to issuance. The Controller must send copies of an audit report and demand for repayment to the DHS Audits and Investigations Division and Office of Administrative Hearings and Appeals. Given these circumstances, the HCFA could reasonably conclude that, as authorized by title 42 Code of Federal Regulations part 431.10(e)(3), the DHS has simply contracted with the Controller to perform required postpayment audits. The HCFA's conclusion that the delegation of audit responsibilities to the Controller is fully compliant with federal single state agency requirements is not plainly erroneous or inconsistent with the regulation. Therefore, it is entitled to and will be accorded controlling weight.

V. DISPOSITION

The trial court's judgment granting a peremptory writ of mandate is reversed. Defendant, the Director of the California Department of Health Services, is to recover its costs on appeal from plaintiff, RCJ Medical Services, Inc.

CERTIFIED FOR PUBLICATION

TURNER, P.J.

We concur:

GRIGNON J.

ARMSTRONG, J.

IN THE COURT OF APPEAL OF THE
STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
DIVISION: 5

DATE: August 30, 2001

Patric Hooper
Hooper Lundy & Bookman, Inc.
1875 Century Park East
Suite 1600
Los Angeles, CA 90067-2104

RCJ Medical Services, Inc.
v.
The Director of the State Department of Health Services

B143160
Los Angeles County No. BS060056

THE COURT:

Petition for rehearing denied.

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Attorneys for Petitioner

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

RCJ MEDICAL SERVICES, INC. dba AMERICAN NETWORK LABORATORY, Petitioner, v. THE DIRECTOR OF THE STATE, ETC. Respondent.	Case No. BS 060056 ~~[PROPOSED]~~ JUDGMENT GRANTING PEREMPTORY WRIT OF MANDATE (Filed May 18, 2000)

Petitioner's Motion for a Peremptory Writ of Mandate in this matter came on regularly for hearing before the Honorable David P. Yaffe, Judge presiding in Department 86 of the within Court, on May 2, 2000. Petitioner, RCJ Medical Services, Inc., was represented by Patric Hooper of Hooper, Lundy & Bookman, Inc., and respondent Director of the State Department of Health Services, was represented by Patricia L. Nagler, Deputy Attorney General.

The Court having considered all of the pleadings and the written and oral argument of counsel, and having issued the tentative decision which is reflected in its Minute Order of May 2, 2000, and which constitutes its Statement of Decision,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that a peremptory writ of mandate be issued requiring the respondent, the Director of the State Department of Health Services to set aside her Final Decision in this case insofar as it relies upon /s/ DPY ~~and to void~~ the audit findings of the State Controller. /s/ DPY ~~which gave rise to the final administrative decision under review~~.

IT IS FURTHER ORDERED that plaintiff shall recover its costs of suit in the amount of $_____.

DATED: May 18, 2000

By: /s/ Judge David P. Yaffe
DAVID P. YAFFE
Judge of the Superior Court

BEFORE THE DEPARTMENT OF HEALTH SERVICES
STATE OF CALIFORNIA
ADMINISTRATIVE HEARINGS

In the Matter of: AMERICAN NETWORK LABORATORY (RCJ Medical Services, Inc. PROVIDER NO. LAB87216F DATE REPORTS ISSUED March 10, 1998 & May 4, 1998	Appeal No. SR8-0298-550-RC SR8-0398-644-RC **FINAL DECISION**

SUMMARY

The appeal is granted in part and denied in part.

The Office of the State Controller has the authority to audit Medi-Cal claims, as long as it complies with federal Medicaid laws and regulations, as well as California Medi-Cal laws and regulations.

The Office of the State Controller may use a valid statistical and extrapolation methodology during its audit process to help determine the amount of an overpayment to a provider, but should disallow payment only at the lower limit of the 95 percent confidence interval.

Evidence introduced into the record supports the conclusion that a laboratory provider should not perform tests where there is no name of the referring physician on the requisition form. In addition, a provider cannot insulate itself from possible financial consequences by relying

on alleged arrangements made by independent contractors with medical clinics and/or doctors regarding the requesting of laboratory tests.

Where sufficient evidence is produced to establish that a provider billed for services in excess of what was ordered by a physician, or did not perform tests that were ordered, audit adjustments taken by the Controller will be upheld.

Where a preponderance of the evidence shows that no eligible Medi-Cal beneficiary received the service that was billed for, payment for the service in question must be disallowed.

PROCEEDINGS

This matter was heard before Robert L. Carisoza, Administrative Law Judge for the Department of Health Services, on June 15 and 16, 1998, in Los Angeles, California. The representatives present were:

Geoffrey F. Margolis, Esq., for the Office of the State Controller (Controller); and

Patric Hooper, Esq., for American Network Laboratory (Provider).

The Names of other persons in attendance are a matter of record. At the conclusion of the formal hearing the administrative record was held open for the submission of written closing arguments. After receipt of these closing arguments, the formal administrative record was closed effective December 9, 1998.

A Proposed Decision was signed by the Administrative Law Judge on April 1, 1999, and was mailed to the parties and to the deputy Director and Chief Counsel for the Department of Health Services with a request for comments. Comments were received from the Controller and from the department of Health Services.

On May 28, 1999, the Provider's counsel notified the Office of Administrative Hearings and Appeals that the published appellate decision in *Doctor's Medical Laboratory, Inc. v. Connell* (1999) 69 Cal.App.4th 891 ("the *Connell* decision") had become final, and asked that the appeal be granted in its entirety based upon the decision. Further briefing on the applicability of the decision was submitted by both parties.

On June 7, 1999, the Proposed Decision was timely rejected, and the parties were given notice that the primary reason for so doing was to consider the effect of the finality of the *Connell* decision. The Provider's counsel waived further briefing on this issue. Subsequently, the parties and the Department of Health Services were given the opportunity to submit additional briefing on the question of the propriety of payment for services not received by a Medi-Cal beneficiary, and all three submitted additional comments in response to this request.

Based upon a review of the entire record, including the transcript, pursuant to Government Code section 11517(d), this constitutes the Final Decision of the Department of Health Services.

ISSUES

1. Whether the Office of the State Controller has authority to audit Medi-Cal claims.

2. Whether the sampling and extrapolation methodology and findings used by the Controller in both of its audits are valid.

For Audit #1:

3. Whether finding #1 is proper in concluding that alleged referring physicians did not actually refer patients to the Provider.

4. Whether finding #2 is correct in concluding that laboratory tests were not ordered by referring physicians or not performed by the Provider.

5. Whether finding #3 is proper in concluding that services were not provided to the claimed beneficiaries, and therefore, the Provider should reimburse the Medi-Cal program.

6. Whether finding #4 is correct in concluding that laboratory tests were not ordered.

For Audit #2:

7. Whether finding #1 is correct in concluding that laboratory tests were not ordered by referring physicians or were not performed by the Provider.

8. Whether finding #2 is proper in concluding that services were not provided to the claimed beneficiaries, and therefore, the Provider should reimburse the Medi-Cal program.

STIPULATION

During the course of the hearing the parties stipulated that the following exhibits would be treated as direct evidence: exhibits 44, 47, 55, 58, 84, 89, 94, and 97.

BACKGROUND FACTS

A preponderance of the oral and documentary evidence introduced into the administrative record during the course of the hearing established the following:

I

The Provider is a general clinical laboratory licensed by the State of California, and certified by the Department to perform diagnostic services for eligible beneficiaries of the Medi-Cal program. Within the scope of this licensing and certification, the Provider performed various laboratory services in the Los Angeles area during the period January 1997 through March 1998, for which the Provider was reimbursed by the Medi-Cal program.

II

Relying on statutory authority and an interagency agreement with the Department of Health Services (Department), the Controller initially conducted a review of the Provider's Medi-Cal claims for medical testing services which were submitted during the period January 9, 1997, through October 9, 1997. The purpose of this review was to determine the Provider's compliance with the applicable provisions of the Medi-Cal program governing the performance of laboratory services. This report

concluded that the Provider had been overpaid[1] $1,296,801.00 by the Medi-Cal program for the services rendered. This overpayment amount was calculated using a statistical extrapolation methodology which projected the findings of the 110 random sample items reviewed to the entire population of 10,857 items. The Controller issued its findings resulting from this review in a final report dated March 10, 1998. The Provider filed a timely appeal from the findings of this report by letter dated March 19, 1998. Thereafter, the Controller conducted a follow-up review of the Provider's Medi-Cal claims submitted for medical testing services which were performed during the period of October 10, 1997, through March 6, 1998. This report concluded that the Provider had been overpaid $164,766.00 by the Medi-Cal program for the services rendered. The Controller issued its findings resulting from this review in a final report dated May 4, 1998. The Provider filed a timely appeal from the findings of this report on May 6, 1998. These two appeals were subsequently consolidated for hearing and decision.

FINDINGS OF FACT AND DETERMINATION OF ISSUES

I

The relationship of the Department of Health Services (Department) with Medi-Cal providers is in the nature of a contract, the terms of which include and are

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[1] Throughout this decision, references to "payment" are to authorization for payment, regardless of the current status of the cash; that is, this decision adjudicates legal ownership of the funds, not their physical possession.

limited by the laws and valid regulations applicable to the Medi-Cal program (*Paramount Convalescent Center, Inc. v. Department of Health Care Services* (1975) 15 Cal.3d 489; *California Medical Association v. Lackner* (1981) 117 Cal.App.3d 552). The Controller conducted an audit of the Provider's records in reliance on California Government Code sections 925.6, 926.15, and 12410, and pursuant to an interagency agreement between the Controller and the Department. The issues in this appeal involve questions of the proper interpretation and application of those laws, regulations, and contract provisions.

CONTROLLER'S AUTHORITY TO AUDIT MEDI-CAL CLAIMS

II

The first issue raised by the Provider concerns the authority of the Controller to audit Medi-Cal claims under either federal or state law.

In summary, the Provider contends that federal medicaid law and regulations prohibit the Controller from conducting Medi-Cal audits as the Department is the single state agency designated to administer the Medicaid program in California. In addition, the Provider argues, California law does not authorize the Controller to audit Medi-Cal claims, but designates the department as the responsible state agency to carry out that function.

These same questions were previously raised and have been addressed by the United States District Court for the Central District of California in the case of *Health Line Clinical Laboratory, Inc.; and RCJ Medical Services, Inc., v. Kathleen Connell, Controller of the State of California, et al.,*

Case No. CV-98-1620-RJK. The court in that case held that the Controller must comply fully with all federal Medicaid laws and regulations, as well as with all applicable Welfare and Institutions Code and California Code of Regulations sections, as it agreed to do in the interagency agreement with the Department, and as required under federal law. If the court had agreed with the Provider's contentions as set forth above, it would have issued a different ruling. Since it did not, it is safe to conclude that the court accepted that the Controller can audit Medi-Cal providers as long as it follows federal Medicaid law and regulations, as well as California's Medi-Cal laws and regulations.[2]

The Provider also argues that the appeal must be granted based on the *Connell* decision, *supra*, in which the Court of Appeal for the Second Appellate District stated that "[t]he Controller could not lawfully exercise power to audit provider payments and withhold alleged excesses." (69 Cal.App.4th at 897). The Provider argues that the Department is bound by the *Connell* decision and must reverse the overpayment disallowance based on the Controller's alleged lack of authority.

In order to determine the impact of the *Connell* decision on this administrative matter, it is critical to observe what was and was not before the court in that case. The Provider filed the action to challenge the Controller's "withhold" (refusal to disburse) of moneys otherwise payable to the Provider. No audit report or audit findings

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[2] It is also noted that the federal court expressly kept itself apprised of the progress of this administrative action, and refused to interfere with its completion.

were in front of the trial court, nor was complete evidence presented as to how the Controller functions as an agent of the Department in connection with the Medi-Cal audit function. The Department was not a party. The Controller based her argument on the constitutional and statutory authority of her office, since the withhold was taken under that authority, which is separate and apart from the audit function performed pursuant to the interagency agreement with the Department.

Although, later on in the *Connell* litigation, the Controller's status as an agent of the Department was argued, that status, and how it relates to the Controller's authority to audit, was never squarely at issue before the Court of Appeal, since no trial court record had been made concerning any audit.

It is unquestionable that the Court of Appeal, in ruling *The Controller's withhold* contrary to federal requirements, and ordering it to be dissolved, did include in its discussion references to *audit* authority. However, such references were not based on a fully developed record, and relate to something that was not factually before the court. Further, the court did not, and had no reason to, discuss the Controller's audit authority standing alone. It was only the authority to "audit . . . and withhold" that was at issue.

With all due respect for the opinion of the Court of Appeal, its very brief discussion of this subject, based on an incomplete record, does not appear to be a dispositive pronouncement concerning the Controller's authority to audit, with the audit leading to an independent evaluation of the case by an Administrative Law Judge of the

Department of Health Services, and a Final Decision of the Department. The court of Appeal was not aware that the coordination of audit resources between the Department and the Controller is pursuant to an interagency agreement that has now been found to be fully in compliance with federal requirements by the responsible federal agency. The record in this administrative case contains a copy of a letter dated March 24, 1999, from Sally K. Richardson, Director, Health Care Financing Administration, stating that the use of Controller's audit resources, in the manner specified in the interagency agreement, to increase the state's ability to identify and recover overpayments, is consistent with California's Medicaid State Plan and applicable federal law. The letter specifically approves the use of federal matching funds by the Controller for audit purposes.

It is also notable that the Court of Appeal for the first Appellate District upheld, albeit without specific comment on the subject, an overpayment determination made by the Department after a Controller's audit. In *Taye v. Coye* (1994) 29 Cal.App.4th 1339, the Court of Appeal accepted the decision resulting from the Department's administrative process as a proper decision, notwithstanding the Controller's involvement as an agent of the Department.

The oblique, indirect way in which the Court of Appeal for the Second District commented on the question of the Controller's audit authority, and the fact that the First District has accepted that authority in a published decision, seen together, create substantial uncertainty in the law, and deprive the Provider's argument, that this appeal must be granted, of a firm foundation.

The Department, having entered into an inter-agency agreement with the Controller that has been approved by both state and federal control agencies, believes that the Controller, as the Department's agent, properly conducted the underlying audit. For the reasons stated, it is concluded that the Department and the Controller should have the opportunity to defend that authority before a court.

EXTRAPOLATION METHODOLOGY

III

The second issue to be addressed deals with the validity of the sampling and extrapolation methodology used by the Controller.

The Provider first contends that the Controller does not have the authority to use sampling and extrapolation methodologies to perform postservice, prepayment audits. This question was not specifically addressed by either court in the cases cited above. However, title 22, California Code of Regulations, section 51159, authorizes the Department to perform postservice prepayment audits to review for program coverage, and payments to providers may be withheld or reduced if the service rendered was inappropriate. In addition, section 51458.2 of the same regulations authorizes the Department to utilize probability sampling to extrapolate the amount to be recovered from a provider.

Based on the two regulations referenced above, it is found that the Controller, as the Department's agent, can use probability sampling to extrapolate the amount to be recovered from the Provider. As to the specific funds

disallowed by the Controller pursuant to its sampling and extrapolation methodologies, a determination must be made as to whether the specific methodologies used to calculate the amount of the overpayment were valid.

IV

The Controller used the identical statistical methodology in audit #1 and #2. The method is called the ratio method of estimation, and was taken from Herbert Arkin's book, *Handbook of Sampling for Auditing and Accounting*, 3rd Edition. The sample selected for audit #1 was a systematic random sample of 110 items from a universe of 10,857, using two random starting points with every 200th item selected. Once the sample items were selected, each was reviewed to determine if payment should be allowed or disallowed. If an item was disallowed it was disallowed for one of four specific reasons, as will be discussed below. Once all sample items were reviewed, allowed and disallowed amounts were totaled. The sample error rate was found to be 60.94 percent with respect to audit #1. When extrapolated to the entire universe, the point estimate for audit #1 was found to be an overpayment of $1,296,801, with a precision of 14.43 percent or margin of error of plus or minus $187,191, at a confidence level of 95 percent. For audit #2, the point estimate was found to be $164,766, with a precision factor or margin of error of plus or minus $81,225.

Experts from both sides testified that the methodology used to select the random sample was appropriate. The Controller's witness further testified that the extrapolation from the sample was proper and that the findings

were accurate. The Controller's expert opined that she could have made the sample and extrapolation tighter but was not consulted prior to the Controller's audit. She felt, however, that using the upper limit would still be appropriate. Although the Provider's expert opined that the extrapolation regarding one finding should not have been done, but instead a complete audit of all claims within that finding should have been undertaken, this tribunal concludes that the Controller's methodology was proper and that its findings were accurate. The Controller's randomly selected sample represented the entire universe, and therefore, a more in-depth analysis of one finding would not have added to the validity of the Controller's findings.

It is found that the Controller's sampling methodology, and extrapolation were appropriate methods, and that the findings were accurate. The Provider argued that using the point estimate is less accurate and reliable than using the lower limit of the precision factor. As the Controller's expert testified, the issue is not one of accuracy, but one of whether one wishes to err in favor of preventing overpayment, or in favor of ensuring that overpayment demands are not overstated. It has been the longstanding interpretation of the Department that the number which more conservatively estimates the overpayment rate, that is, the lower limit of the 95 percent confidence interval, should be used. There is no rational basis for deviating from that interpretation simply because the Controller's auditors conducted the audit.

Therefore, when calculating the Provider's overpayment, the lower limit shall be used. Consequently, the maximum overpayment to the Provider for audit #1 can

only be $1,109,610, which is the point estimate of $1,296,801 minus the margin of error of $187,191. The maximum overpayment to the Provider for audit #2 can only be $83,541, using the same formula.

V

The next issue deals with finding #1 of audit #1, and concerns the question of whether alleged referring physicians actually referred patients to the Provider.

The Controller contends that the Provider billed for laboratory tests that were never requested, according to the referring physician indicated on the laboratory requisition. Of the 110 sample items, 20 were referred by a Dr. Herrera. When Dr. Herrera was interviewed by the Controller's auditors, he denied ever having treated any of the 20 patients, and denied requesting any lab tests from the Provider. In addition, he denied having worked at Clinica Santa Maria, where these 20 patients were alleged to have been treated by Dr. Herrera. Finally, he denied having signed a comprehensive master panel agreement with the Provider, and denied having signed an application to obtain a Medi-Cal provider number.

Dr. Herrera testified and confirmed the above statements. In addition, he testified that Dr. Villamizar was the medical director of Clinica Santa Maria. Although Dr. Herrera worked for Dr. Villamizar at Los Angeles Specialist Medical Management, he did not work for him at Clinica Santa Maria.

The Provider argues that whether Dr. Herrera states he was actually associated with Clinica Santa Maria is not

important. The Provider contends that evidence presented by the Controller establishes that Dr. Herrerra was in fact associated with this clinic, and this is confirmed by statements made by medical personnel at the clinic to the Controller auditors. Given these circumstances, the Provider had no basis or reason for concluding that Dr. Herrera was "secretly" not associated with the clinic, and therefore, the Provider was required to perform those tests ordered on the requisition sheets it received from Clinica Santa Maria. As a consequence, since the Provider is required to perform tests only at the written request of an authorized person, and the Provider did so in the present matter, the laboratory services must be deemed to be covered Medi-Cal services even if Dr. Herrera testifies now that he is not associated with the clinic.

VI

Title 22, California Code of Regulations, section 51311, entitled "Laboratory, Radiological and Radioisotope Services" provides in pertinent part:

> "Examinations, tests . . . ordered by a licensed practitioner, within his scope of practice . . . for prevention, diagnosis and treatment of illness or injury are covered . . . "

In addition, section 51458.1 of those same regulations provides:

> "(a) The Department shall recover overpayments to provider including, but not limited to, payments determined to be:
>
> . . .

(11) For services not ordered or prescribed, when an order or prescription is required. . . . "

The "written request . . . of an authorized person" is required before laboratory tests can be performed. Title 42, Code of Federal Regulations, section 493.1105. This request often times is in the form of a "test requisition form." To be valid, this form must meet certain requirements such as those set forth in the federal regulation. Section 493.1105 provides that the test requisition should contain the patient's name; the name and address of the authorized person requesting the test and, where applicable, a contact person to enable the reporting of imminent life-threatening laboratory results or panic values; the tests to be performed; the date of specimen collection; and any additional information relevant and necessary to assure accurate and timely testing and reporting of test results.

Exhibit 24 was presented, which relates to the first sample patient under this finding. Exhibit 24 is a requisition form from Clinica Santa Maria. It contains a patient name and address, the name, address, and telephone number of the clinic, the date and time the specimen was received by the lab, the tests requested to be performed, but no name of the authorized person requesting the tests. In addition, this exhibit contains a client identification number which allegedly refers to the person authorizing the tests to be performed. There is no name of any contact person in order to clarify the request, or to report life-threatening laboratory results or panic values. Exhibit 25 presented for the second sample patient contained exactly the same type of information reported as exhibit 24.

It is concluded that the name of the authorized person requesting lab tests is required on the test requisition form before a laboratory can perform those tests. A clinic is not a physician. Requiring the name of the authorizing physician to appear on the lab form protects both the clinical laboratory and the requesting physician. It protects the clinical laboratory from subsequent claims that the tests it performed were not requested or were not requested by an authorized person. It protects the physician from false allegations by clinical laboratories that a physician authorized requested tests. If the physician's name is not there, then that physician did not authorize any tests to be performed.

In this case, the alleged requesting physician, who is identified on the test requisition form only by a typed client number and not by name, claims never to have worked at the medical clinic, nor to have requested any tests for any of the patients. In addition, this physician claims never to have signed any comprehensive panel agreement with the Provider. On the other hand, the Provider claims to have an arrangement with this physician who was given a client identification number. The arrangement was that when the physician ordered a Comprehensive Panel he meant a specific list of tests of which the provider had knowledge. The Provider supplied the clinic with preprinted forms identifying the physician by a client identification number, and the clinic by name and address.

A careful review of the documents submitted into evidence which contain the physician's signature was conducted by the Administrative Law Judge, and he found that the signatures on the comprehensive panel

agreement with the Provider and the application for Medi-Cal provider number are not the signature of Dr. Herrera. The Administrative Law Judge's credibility finding in this regard will not be disturbed.

The first question to be answered for this issue is not whether Dr. Herrera did or did not request lab work from the Provider, but whether, based upon the lab requisition forms the Provider received from Clinica Santa Maria, the Provider had any reason to believe that these requisitions were valid requests for lab tests. On their face, the lab requisitions appear to be valid requests for tests. Although there is no name of the person authorizing the tests, the Provider has been told by an independent contractor that client ID # 183 is Dr. Herrera, who works at Clinica Santa Maria.

During the course of the administrative hearing, evidence was presented which established that the Provider had agreements with four independent[3] contractors. According to these agreements, each independent contractor was assigned a territory where he or she would create a place into operation a sales marketing plan, and would be paid up to a 30 percent commission on the net collected sales it brought into the Provider's business each month. For example, for each comprehensive panel that was referred to the Provider, and subsequently paid for, the independent contractors would receive anywhere from $120.00 to $130.00. These independent contractors

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[3] This is the term used by the Provider. However, the record reflects that one was the owner of a clinic that referred business to the laboratory, and some were owners of the laboratory. (Transcript 6-15-1998, p. 14; 6-16-1998, p. 128.)

established the arrangements with referring physicians and/or clinics, and set up the accounts with the Provider. Once these arrangements were made, and the account set up, the Provider's couriers would pick up the specimens from the clinics. The Provider would supply the physicians and clinics with the preprinted lab requisition forms with their client identifications number. When the Provider later received one of these forms, along with the specimens, it would perform the requested tests, report the findings back to the client, and bill Medi-Cal if applicable.[4]

It appears that the Provider is attempting to insulate itself from having any responsibility or obligation to verify the arrangements made by its independent contractors. It has created an incentive for its independent contractors to bring in as much business as possible, yet is trying to place itself in a situation where it can rely on the arrangements made by the independent contractors, receive payment for tests it performs, and not be responsible if the tests it performs have never been requested by an authorized physician, or if the alleged patient was never seen by a physician or at a clinic. The Provider cannot create the environment for potential dishonesty to occur, but absolve itself of any responsibility by relying on the word of the independent contractors. The Medi-Cal program is not responsible for the error in judgment or the bad business practices engaged in by the Provider.

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[4] These types of arrangements may be illegal (See *People* v. *Duz-Mor Diagnostic Laboratory, Inc.* (1998) 68 Cal.App.4th 654), but this argument was not raised during the course of the administrative hearing.

If the Provider wants to rely on the arrangements made by the independent contractors without any further verification of their authenticity, then the Provider should be prepared to suffer the consequences, i.e., to be found liable for overpayments to the Medi-Cal program if the independent contractor's business proves inadequately supported.

The appeal on this issue is denied.

VII

The next issue concerns finding #2 relating to specific laboratory tests that were not ordered by the referring physicians or were not performed.

The Controller contends that the Provider billed the Medi-Cal program for laboratory tests that were in excess of those ordered by the referring physicians, as well as for some that were not performed by the laboratory. The auditors analyzed the lab requisitions, the physician comprehensive panel agreements, and the test results, and compared this information to the Provider's billings to the Medi-Cal program. The test results indicate whether a test was performed or not. The test results, if any, were then compared with what was paid to the Provider. The Provider was paid, in many instances, for a test it did not perform either because there are no test results for a lab procedure that was paid for, or because the test results show a "QNS" which means quantity was not sufficient to run the test. In other instances, the physicians did not order a specific test, yet the Provider was paid for performing such a test.

The parties agreed to present evidence on four samples under this finding. The first sample was # 53. This sample relates to a hepatitis panel, a thyroid study and several other tests that were paid for by Medi-Cal, but when the test results are reviewed for that patient on that date of service, there are no test results for a hepatitis panel or thyroid study, etc., because of QNS. That is, there was insufficient blood sample to run the tests. The Controller's auditor testified that she followed the same process in the other three samples and the results were the same, except that some tests billed for were never ordered, while other tests were performed by another laboratory.

The Provider is not entitled to payment for tests that it did not perform for whatever reason, for tests performed by another laboratory, or for tests never ordered. (Title 22, Cal. Code Regs. §51458.1(4).) The appeal on this issue is denied.

VIII

The next issue involves finding #3 which deals with services not provided to the claimed beneficiary. This issue will be discussed below, together with finding #2 of audit #2, which presents the same reason for the overpayment demand.

IX

The next issue relates to finding #4 which deals with tests that were never ordered by a physician.

The Controller contends that the Provider billed Medi-Cal for laboratory tests that were not supported by the referring physician's medical records. In two cases, the physician medical records disclosed that the laboratory tests were never ordered for the dates of service in question.

For the first sample, exhibits 64 and 65 were reviewed. The auditor compared the lab requisition form of the Provider with the medical records of the physician for the patient for which the lab tests were performed. The lab requisition indicated a specific date of service while the medical records for that patient on that same date do not indicate any visit by the patient to the physician. The medical chart also does not indicate that any tests were ordered on that specific date nor does the patient chart contain any test results relating to that date. In addition, other documents indicate that one of the patients in question was actually incarcerated during the entire time period covered by the audit, and remained in custody as of June 11, 1998. Although this evidence is hearsay, it may be used to corroborate the direct testimony of the auditor.

A careful review of exhibit 64, relating to the first sample, indicates that this is a lab test request from client #250, FHC Medical Center. Client #250 is Dr. Malabanan, who works at FHC Medical Center. This lab request indicates a comprehensive panel 1 should be performed. Exhibit 12 introduced by the Controller indicates that Dr. Malabanan worked for FHC Medical Center, and did have a valid agreement with the Provider regarding comprehensive/master panels. Lab results from the tests performed by the Provider are included in exhibit 64.

The next sample involves exhibits 62, 63, and 97. Again, the lab requisition is from client #250, Dr. Malabanan, and requests that a comprehensive panel 1 be performed. The test results are included in this exhibit. The lab request (exhibit 62) was compared with the medical chart (exhibit 63) for the specific patient and date of service in question. Again it was found that the patient chart indicates that: 1) the patient was not seen by the doctor on the date in question, 2) there were no lab tests ordered by the physician for the date in question, and 3) no test results were found in the patient medical chart for that date of service. Exhibit 97 is the signed statement of the Medi-Cal beneficiary that she did not have blood drawn from any physician in the last few years, and has never lived at the address indicated on exhibit 62.

In connection with these sample cases, the Provider had in its files what appeared to be valid lab requisitions from a physician with whom it had a valid agreement. The lab requisitions requested the Provider to perform the indicated test panels. The Provider performed the tests and the test results are included in the exhibits.

The Controller disallowed both of these examples on the basis that the tests were never ordered by the physician. The evidence supports this conclusion. The physician's file was devoid of any evidence that anyone had been seen in connection with the laboratory requests at issue, there was no evidence the services had been ordered, and there was no evidence the results had been received. The Provider failed to rebut the prima facie case made by this absence of any support for its documents.

In addition, the Controller has made the case that no Medi-Cal beneficiary received the services in question, since there was no evidence that the patient was seen or had blood drawn on the date in question.

Where there is no evidence that the physician who supposedly ordered the laboratory test saw the beneficiary-patient, and no evidence that he ordered the tests at issue, the Medi-Cal program is not required to pay for tests of which only the Provider has any documentation. As has been discussed above, the requirement to pay for laboratory services is conditioned on the existence of a valid order from a person authorized to make one. As is further discussed below, it is also conditioned on the receipt of the service by a Medi-Cal beneficiary. Neither was proven to exist in these cases. The appeal is denied as to this finding.

X

The next issue deals with audit #2, finding #1 which is similar to finding #2 of the first audit, i.e. test were not ordered by the referring physician or were not performed. Two samples were presented on this issue.

Dr. Dix was called as a witness by the Controller and he testified regarding this specific finding. Exhibit 69 is his signed statement. Dr. Dix testified that he worked for Divine Health Care which was primarily a personal injury clinic. Due to his patients' conditions he would only order a CBC and electrolytes, and generally would not order any comprehensive panels for any of his patients. He would usually just prescribe physical therapy for his patients. While working at Divine Health Care

he ordered fewer than five lab tests, and to his knowledge he has not referred any lab work to the Provider.

The Controller submitted exhibits 69. 70, and 71 with respect to the first sample. Exhibit 70 is the lab requisition from Divine Health Care, and this form contains the name of Dr. Dix. The requisition requests that a comprehensive panel be done. The Provider performed the tests, and the results are contained in the exhibit. The Controller disallowed all tests of this sample because they were not ordered by Dr. Dix.

With respect to his first sample, it is the determination of this tribunal that the appeal must be denied. The Provider did not have a comprehensive panel agreement with Dr. Dix, who was the medical director of Divine Health care. Therefore, when the Provider received this lab requisition from Dr. Dix requesting a comprehensive panel, it should have contacted Dr. Dix to clarify what tests he wanted performed. Instead, the Provider relied upon an agreement it had with a Dr. Adhami, who was somehow allegedly associated with Divine Health Care, and performed the tests he and the Provider had agreed to. Dr. Dix testified that he did not know a Dr. Adhami. The Provider performed tests that were not ordered by the referring physician. As a consequence, the appeal on this sample must be denied.

Exhibits 72, 73, and 74 were submitted regarding the second sample. Dr. Hsu, the referring physician in this sample, does not have an agreement with the Provider, but does use the Provider. He will only order specific tests. The Controller's review of the patient chart, the lab requisition, and the lab results indicated that the Provider

billed for tests that were not ordered by the physician, and not performed by the Provider. The evidence submitted supports the conclusion of the Controller on this sample item. The Provider was paid for tests that were not ordered or were not performed. The appeal on this sample is denied.

As the appeals on both samples were denied, the appeal on this entire issue must be denied.

XI

The last issue deals with finding #2 of audit #2 which is the same as finding #3 in audit #1. The Controller contends that the Provider billed Medi-Cal for services that were not provided to the beneficiaries indicated on the Provider's laboratory requisition forms. In connection with the first audit period, eight beneficiaries were interviewed by the Controller's auditors and they all signed statements that they had never been to nor received medical services from the medical clinics that were designated on the Provider's lab requisitions. In addition, they all stated that they had never lived at the addresses indicated on the lab requisitions. Exhibit 39 lists the eight Medi-Cal beneficiaries that were interviewed and they were designated as sample #'s 102, 104, 98, 57, 47, 110, 106, and 100. In connection with the second audit period, four beneficiaries were interviewed by the Controller's auditors and all four said they did not receive the medical services in question.

The Controller disallowed all of the services associated with these samples because they were never provided to the named beneficiaries. In some cases, there is

evidence that the service was provided to a patient, but that patient was someone other than the person whose Medi-Cal number appeared on the billing. The Controller argues that the Provider may not bill Medi-Cal for these services pursuant to title 22, California Code of Regulations, section 51470, which provides that:

> "(a) A provider shall not bill or submit a claim to the Department . . . for Medi-Cal benefits not provided to a Medi-Cal beneficiary. . . . "

The Controller states that the regulation is clear and unambiguous, not subject to any exception for providers who do not personally deal with program beneficiaries.

Provider argues that it is not responsible for verifying that a Medi-Cal beneficiary was actually seen at a clinic or by a specific physician. The Provider should be allowed to rely, it argues, on the physician order forms requesting the performance of certain tests, because it has no way of knowing whether a Medi-Cal beneficiary was seen at a clinic or by a physician. The Provider's position is that section 51470 may not be applied to deny payment to a provider who has no personal contact with the beneficiary, and has no obligation to verify the beneficiary's identity.

Input was received from the Department on this issue. The Department likened the laboratory requisition for services which did not benefit any program beneficiary to a forged instrument of title or counterfeit currency. The innocent[5] holder in due course of the inherently

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[5] The Controller did not rule out the possibility that these cases involved beneficiary fraud, where neither the clinic nor

worthless paper has recourse only against the person from whom he obtained it. He cannot force another equally innocent party (e.g., a bank) to accept it as having value, once its valueless nature is discovered.

The regulation at issue is a part of the Department's effort to comply with federal requirements related to the Medi-Cal program. Section 1903(a)(1) of the Social Security Act (codified at 42 U.S.C.A. § 1396b(a)(1)) specifies that a state may receive federal funds for program benefits to the extent they constituted "medical assistance under the State plan." Section 1903(u) (42 U.S.C.A. § 1396b(u)) requires a denial of federal sharing in "erroneous excess payments" (erroneous payments above a tolerance level for error) made by a state Medicaid agency. One of the two definitions of the term "erroneous excess payments" is "payments under the State plan with respect to ineligible individuals and families."

This requirement is echoed in title 42, Code of Federal Regulations, section 431.812(d), which specifies that, as part of its quality control effort, the state Medicaid agency must "identify erroneous payments resulting from – (1) Ineligibility for Medicaid."

From reviewing this basic federal requirement that all Medicaid expenditures must be for covered services to eligible beneficiaries, no exception appears for services rendered in erroneous reliance on a referring provider's false information concerning the issue of whether a covered, eligible beneficiary was in fact the subject of the

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the laboratory was aware that the patient was not the beneficiary, so this is one possible explanation.

referred service. The federal definitions of proper and erroneous Medicaid expenditures are as straightforward as the state regulation at title 22, California Code of Regulations, section 51470. It therefore appears that the Controller's interpretation of section 51470 as an absolute prohibition of payment is correct.[6] Similarly, the Department's input correctly states that the laboratory's position, in the event that it is a totally innocent recipient of a requisition for services that will not benefit a legitimate, eligible individual, is like that of the person who tries to put a counterfeit $100 bill in his bank account. It is not the fault of the bank that the bill is worthless, and the bank owes the depositor no compensation. Just so, the Medicaid agency, having received nothing of value (and nothing which may be paid for with federal funds), owes the Provider no compensation for a service to a person who is not eligible for benefits.

XII

Once it has been determined that the Provider may not be reimbursed with Medi-Cal funds for a service not rendered to an eligible Medi-Cal beneficiary, the question becomes one of whether the Controller met its burden of proving that this lack of an eligible patient occurred in the sample cases at issue. The issue must be proven through competent direct evidence, because the

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[6] Although there are Medi-Cal services which are not subject to federal sharing, and thus would not be found by federal requirements, there has been no suggestion that this is true of any of the services at issue in this case.

Provider's counsel objected to the use of hearsay to support any finding (Government Code § 11513(d)).

Of the twelve cases the Controller presented on this issue, only hearsay was presented on eight. The appeal must be granted to the extent the overpayment determination rests on the eight sample cases unsupported by direct evidence.

The beneficiary testified in each of the other four cases.

The first beneficiary who testified (relating to case #137) was C.L. (Transcript 6-15-98, pp. 96 et seq.). C.L. credibly testified that she did not visit the physician who supposedly ordered laboratory tests on her behalf, nor did she receive any medical care at the clinic in question on the date in question. She also testified that she does not live, and has not lived, at the address shown on the laboratory requisition.

Beneficiary S.S. then testified relating to case #100 (Transcript 6-15-98, pp. 102 et seq.). S.S. attempted to testify that she did not receive the services in question, but her testimony is somewhat confusing and unclear due to her limited command of English and her illiteracy.

The third witness, A.L., testified in relation to case # 57 (Transcript 6-15-98, pp. 110 et seq.). This witness credibly testified that she did not receive any medical services through the physician who allegedly ordered laboratory services on her behalf, and did not go to the clinic where the physician allegedly did so. She also testified that she has never lived at the address attributed to her on the laboratory requisition.

The fourth witness, S.C., attempted to testify in support of the Controller's case # 110 (Transcript 6-15-98, pp. 117 et seq.). However, the Administrative Law Judge found that S.C did not have sufficient command of the English language to testify without an interpreter.[7]

It is concluded that the Controller presented sufficient evidence to prevail on cases 137 and 57. C.L. and A.L. both testified with sufficient clarity and credibility to support the allegation that they did not receive the services at issue. No evidence was presented to show that any other eligible beneficiary received them in their stead. Because the evidence presented in support of cases 100 and 110 was not sufficient, the appeal is granted as to the portion of the overpayment represented by those cases.

ORDER

The Office of the State Controller has the authority to audit Medi-Cal providers, and may use probability sampling to extrapolate the amount to be recovered from the Provider.

The Provider's appeal is granted in part as to Issues #5 and #8. As to those issues, the appeal is denied as to that portion of the overpayment determination which is supported by direct testimony, and granted in the remainder. The controller is directed to recalculate that

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[7] The Controller made a late request for an interpreter, but one could not be secured in the time remaining before the hearing.

portion of the overpayment determination consistent with the substance of this Decision.

The appeal is denied in all other respects.

The Controller is also ordered to recalculate the overpayment to the Provider consistent with the views expressed in this Decision by using the lower limit of the 95 percent confidence interval.

Pursuant to the authority duly vested in me, I hereby adopt the foregoing as the Final Decision of the Department of Health Services.

This Final Decision is signed on August 6, 1999 and shall be effective immediately.

/s/ Joseph P. Munso
Joseph P. Munso
Chief Deputy Director

IN THE COURT OF APPEAL OF THE
STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
JOSEPH A. LANE, CLERK

DIVISION 5

Los Angeles County Superior Court
111 North Hill Street
Los Angeles, CA 90012

RCJ Medical Services, Inc.
v.
The Director of the State Department of
Health Services
B143160
Los Angeles County No. BS060056

*****REMITTITUR*****

I, Joseph A. Lane, Clerk of the Court of Appeal of the State of California, for the Second Appellate District, do hereby certify that the attached is a true and correct copy of the original order, opinion or decision entered in the above-entitled cause on August 23, 2001 and that this order, opinion or decision has now become final.

Defendant to recover costs from plaintiff.

Witness my hand and the seal of
the Court affixed at my office
this Dec. 28, 2001

Joseph A. Lane, Clerk

by: _____
Deputy Clerk

cc: All Counsel (w/out attachment)
File

Court of Appeal, Second Appellate District, Division Five – No. B143160

S100878

IN THE SUPREME COURT OF CALIFORNIA

En Banc

RCJ MEDICAL SERVICES INCORPORATED, Plaintiff and Respondent,

v.

THE DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES, et al., Defendants and Appellants.

(Filed Dec. 12, 2001)

Petition for review DENIED.

GEORGE
Chief Justice

42 U.S.C. § 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must –

* * *

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

* * *

(9) provide –

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services.

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

* * *

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view of maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

* * *

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any

payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

* * *

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

* * *

42 C.F.R. § 430.10 The State plan.

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

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42 C.F.R. § 430.12 Submittal of State plans and plan amendments.

* * *

(c) *Plan amendments.* (1) The plan must provide that it will be amended whenever necessary to reflect –

* * *

(ii) Material changes in State law, organization, or policy, or in the State's operation of the Medicaid program. For changes related to advance directive requirements, amendments must be submitted as soon as possible, but no later than 60 days from the effective date of the change to State law concerning advance directives.

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42 C.F.R. § 430.20 Effective dates of State plans and plan amendments.

For purposes of FFP, the following rules apply:

(a) *New plans.* The effective date of a new plan –

(1) May not be earlier than the first day of the quarter in which an approvable plan is submitted to the regional office; and

(2) With respect to expenditures for medical assistance, may not be earlier than the first day on which the plan is in operation on a statewide basis.

(b) *Plan amendment.* (1) For a plan amendment that provides additional services to individuals eligible under the approved plan, increases the payment amounts for services already included in the plan, or makes additional groups eligible for services provided under the approved plan, the effective date is determined in accordance with paragraph (a) of this section.

(2) For a plan amendment that changes the State's payment method and standards, the rules of § 447.256 of this chapter apply.

(3) For other plan amendments, the effective date may be a date requested by the State if HCFA approves it.

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42 C.F.R. § 431.10 Single State agency.

(a) *Basis and purpose.* This section implements section 1902(a)(5) of the Act, which provides for designation of a single State agency for the Medicaid program.

(b) *Designation and certification.* A State plan must –

(1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and

(2) Include a certification by the State Attorney General, citing the legal authority for the single State agency to –

(i) Administer or supervise the administration of the plan; and

(ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

(c) *Determination of eligibility.* (1) The plan must specify whether the agency that determines eligibility for families and for individuals under 21 is –

(i) The Medicaid agency; or

(ii) The single State agency for the financial assistance program under title IV-A (in the 50 States or the District of Columbia), or under title I or XVI (AABD), in Guam, Puerto Rico, or the Virgin Islands.

(2) The plan must specify whether the agency that determines eligibility for the aged, blind, or disabled is –

(i) The Medicaid agency;

(ii) The single State agency for the financial assistance program under title IV-A (in the 50 States or the District of Columbia) or under title I or XVI (AABD), in Guam, Puerto Rico, or the Virgin Islands; or

(iii) The Federal agency administering the supplemental security income program under title XVI (SSI). In this case, the plan must also specify whether the Medicaid agency or the title IV-A agency determines eligibility for any groups whose eligibility is not determined by the Federal agency.

(d) *Agreement with Federal or State agencies.* The plan must provide for written agreements between the Medicaid agency and the Federal or other State agencies that determine eligibility for Medicaid, stating the relationships and respective responsibilities of the agencies.

(e) *Authority of the single State agency.* In order for an agency to qualify as the Medicaid agency –

(1) The agency must not delegate, to other than its own officials, authority to –

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

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42 C.F.R. § 431.11 Organization for administration.

(a) *Basis and purpose.* This section, based on section 1902(a)(4) of the Act, prescribes the general organization and staffing requirements for the Medicaid agency and the State plan.

(b) *Medical assistance unit.* A State plan must provide for a medical assistance unit within the Medicaid agency, staffed with a program director and other appropriate personnel who participate in the development, analysis, and evaluation of the Medicaid program.

(c) *Description of organization.* (1) The plan must include –

(i) A description of the organization and functions of the Medicaid agency and an organization chart;

(ii) A description of the organization and functions of the medical assistance unit and an organization chart; and

(iii) A description of the kinds and number of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) *Eligibility determined by other agencies.* If eligibility is determined by State agencies other than the Medicaid agency or by local agencies under the supervision of other State agencies, the plan must include a description of the staff designated by those other agencies and the functions they perform in carrying out their responsibility.

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42 C.F.R. § 431.610 Relations with standard-setting and survey agencies.

(a) *Basis and purpose.* This section implements –

(1) Section 1902(a)(9) of the Act, concerning the designation of State authorities to be responsible for establishing and maintaining health and other standards for institutions participating in Medicaid; and

(2) Section 1902(a)(33) of the Act, concerning the designation of the State licensing agency to be responsible for determining whether institutions and agencies meet requirements for participation in the State's Medicaid program.

(3) Section 1919(g)(1)(A) of the Act, concerning responsibilities of the State for certifying the compliance of non-State operated NFs with requirements of participation in the State's Medicaid program.

(b) *Designated agency responsible for health standards.* A State plan must designate, as the State authority responsible for establishing and maintaining health standards for private or public institutions that provide services to Medicaid recipients, the same State agency that is used by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare (see 42 CFR 405.1902). The requirement for establishing and maintaining standards does not apply with respect to Christian Science sanitoria operated, or listed and certified, by the First Church of Christ Scientist, Boston, Mass.

(c) *Designated agency responsible for standards other than health standards.* The plan must designate the Medicaid agency or other appropriate State authority or authorities to be responsible for establishing and maintaining standards, other than those relating to health, for private or public institutions that provide services to Medicaid recipients.

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42 C.F.R. § 447.45 Timely claims payment.

(a) *Basis and purpose.* This section implements section 1902(a)(37) of the Act by specifying –

(1) State plan requirements for –

(i) Timely processing of claims for payment;

(ii) Prepayment and postpayment claims reviews; and

(2) Conditions under which the Administrator may grant waivers of the time requirements.

(b) *Definitions. Claim* means (1) a bill for services, (2) a line item of service, or (3) all services for one recipient within a bill.

Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not

include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

A *shared health facility* means any arrangement in which –

(1) Two or more health care practitioners practice their professions at a common physical location;

(2) The practitioners share common waiting areas, examining rooms, treatment rooms, or other space, the services of supporting staff, or equipment;

(3) The practitioners have a person (who may himself be a practitioner) –

(i) Who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at the common physical location other than the direct furnishing of professional health care services by the practitioners to their patients; or

(ii) Who makes available to the practitioners the services of supporting staff who are not employees of the practitioners; and

(iii) Who is compensated in whole or in part, for the use of the common physical location or related support services, on a basis related to amounts charged or collected for the services rendered or ordered at the location or on any basis clearly unrelated to the value of the services provided by the person; and

(4) At least one of the practitioners received payments on a fee-for-service basis under titles V, XVIII, and

XIX in an amount exceeding $5,000 for any one month during the preceding 12 months or in an aggregate amount exceeding $40,000 during the preceding 12 months.

The term does not include a provider of services (as specified in § 489.2(b) of this chapter), a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), a hospital cooperative shared services organization meeting the requirements of section 501(e) of the Internal Revenue Code of 1954, or any public entity.

Third party is defined in § 433.135 of this chapter.

(c) *State plan requirements.* A State plan must (1) provide that the requirements of paragraphs (d), (e)(2), (f) and (g) of this section are met; and

(2) Specify the definition of a claim, as provided in paragraph (b) of this section, to be used in meeting the requirements for timely claims payment. The definition may vary by type of service (e.g., physician service, hospital service).

(d) *Timely processing of claims.* (1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.

(2) The agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt.

(3) The agency must pay 99 percent of all clean claims from practitioners, who are in individual or group

practice or who practice in shared health facilities, within 90 days of the date of receipt.

(4) The agency must pay all other claims within 12 months of the date of receipt, except in the following circumstances:

(i) This time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system, as defined in § 447.272 of this part.

(ii) If a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid claim relating to the same services within 6 months after the agency or the provider receives notice of the disposition of the Medicare claim.

(iii) The time limitation does not apply to claims from providers under investigation for fraud or abuse.

(iv) The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

(5) The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim.

(6) The date of payment is the date of the check or other form of payment.

(e) *Waivers.* (1) The Administrator may waive the requirements of paragraphs (d) (2) and (3) of this section

upon request by an agency if he finds that the agency has shown good faith in trying to meet them. In deciding whether the agency has shown good faith, the Administrator will consider whether the agency has received an unusually high volume of claims which are not clean claims, and whether the agency is making diligent efforts to implement an automated claims processing and information retrieval system.

(2) The agency's request for a waiver must contain a written plan of correction specifying all steps it will take to meet the requirements of this section.

(3) The Administrator will review each case and if he approves a waiver, will specify its expiration date, based on the State's capability and efforts to meet the requirements of this section.

(f) *Prepayment and postpayment claims review.* (1) For all claims, the agency must conduct prepayment claims review consisting of –

(i) Verification that the recipient was included in the eligibility file and that the provider was authorized to furnish the service at the time the service was furnished;

(ii) Checks that the number of visits and services delivered are logically consistent with the recipient's characteristics and circumstances, such as type of illness, age, sex, service location;

(iii) Verification that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed;

(iv) Verification that a payment does not exceed any reimbursement rates or limits in the State plan; and

(v) Checks for third party liability within the requirements of § 433.137 of this chapter.

(2) The agency must conduct postpayment claims review that meets the requirements of parts 455 and 456 of this chapter, dealing with fraud and utilization control.

* * *

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 654-0391

December 17, 1999

Ms Linda Minamoto
Associate Regional Administrator
DHHS Health Care Financing Administration
Division of Medicaid-Region IX
75 Hawthorne Street, Fourth Floor
San Francisco, CA 94105

Dear Ms. Minamoto:

STATE PLAN AMENDMENT 99-011

The Department of Health Services is submitting the enclosed State Plan Amendment to recognize the California State Controllers Office and their performance of audits of Medi-Cal program providers.

For this amendment, we are requesting an effective date of July 1, 1998. If you have any questions on this amendment, please contact Mr. Joseph A. Kelly, Chief of the Medi-Cal Policy Division, at (916) 657-1542.

Sincerely,

/s/ Stan Rosenstein
Stan Rosenstein
Acting Deputy Director
Medical Care Services

Enclosure

STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER: 99-011
2. STATE: CA
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
4. PROPOSED EFFECTIVE DATE: July 1, 1998
5. TYPE OF PLAN MATERIAL (*Check One*):
   [ ] NEW STATE PLAN
   [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN
   [x] AMENDMENT

COMPLETE BLOCKS 6 THRU 10 OF IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:
7. FEDERAL BUDGET IMPACT:
   a. FFY _____ $_____
   b. FFY _____ $_____
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 1.2-A (page labeled as 25 – Audits & Investigations)
9. PAGE NUMBER OF THE SUPERVISED PLAN SECTION OR ATTACHMENT (*If Applicable*) Same

10. SUBJECT OF AMENDMENT: State Controller's Office-Authority to Audit

11. GOVERNOR'S REVIEW (*Check One*):

[ ] GOVERNOR'S OFFICE REPORTED NO COMMENT
[ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
[ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
[x] OTHER AS SPECIFIED: Governor's Office does not wish to review State Plan amendments.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/ Stan Rosenstein

13. TYPED NAME: Stan Rosenstein

14. TITLE: Acting Deputy Director

15. DATE SUBMITTED: 12/17/99

16. RETURN TO: Department of Health Services
714 P Street, Room 1640
Sacramento, CA 95814

Attn: State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME

22. TITLE:

REMARKS:

Attachment 1.2-A

AUDITS AND INVESTIGATIONS DIVISION

* * *

F. The State Controller's Office will perform audits of Medi-Cal expenditures on behalf of DHS and will submit its findings and recommendations to DHS for appropriate action.

No. 99-011 Approval Date: _____ Effective Date _____

[LOGO] **DEPARTMENT OF HEALTH & HUMAN SERVICES**

[Address Omitted in Printing]

Dec. 17, 1999

Stan Rosenstein, Acting Deputy Director
Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814

Dear Mr. Rosenstein:

Enclosed is a copy of California State plan amendment (SPA) No. 99-011, which we have approved effective July 1, 1998, as you requested. SPA 99-011 amends the State plan to reflect the fact that the State Controller's Office performs audits of Medi-Cal expenditures on behalf of the Department of Health Services (DHS).

Our review of SPA No. 99-011 was conducted in accordance with the requirements of section 1902(a)(5) of the Social Security Act (the Act) and the regulatory provisions at 42 CFR 431.10 and 431.11.

Should you have any questions regarding our approval of this SPA, please contact Pat Daley at (415) 744-3592.

Sincerely,

/s/ Karen Fuller for
Linda Minamoto
Associate Regional
Administrator
Division of Medicaid

Enclosure

cc: Elliott Weisman, HCFA, Center for Medicaid and State Operations Barbara Hardiman, DHS, California State Plan Coordinator

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STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER: 99-011

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE: July 1, 1998

5. TYPE OF PLAN MATERIAL (*Check One*):
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    [ ] GOVERNOR'S OFFICE REPORTED NO COMMENT
    [ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
    [ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
    [x] OTHER AS SPECIFIED: Governor's Office does not wish to review State Plan amendments.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
    /s/ Stan Rosenstein

13. TYPED NAME: Stan Rosenstein

14. TITLE: Acting Deputy Director

15. DATE SUBMITTED: 12/17/99

16. RETURN TO: Department of Health Services
    714 P Street, Room 1640
    Sacramento, CA 95814

    Attn: State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/17/99

18. DATE APPROVED: 12/17/99

    PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 1998

20. SIGNATURE OF REGIONAL OFFICIAL: /s/ Karen Fuller for

21. TYPED NAME: Linda Minamoto

22. TITLE: Associate Regional Administrator
    Division of Medicaid

REMARKS:

Attachment 1.2-A

AUDITS AND INVESTIGATION DIVISION

* * *

F. The State Controller's Office will perform audits of Medi-Cal expenditures on behalf of DHS and will submit its findings and recommendations to DHS for appropriate action.

Approval Date: Dec. 17, 1999 Effective Date: 7/1/98

DOCTOR'S MEDICAL LABORATORY, INC. *v.* CONNELL
69 Cal.App.4th 891; 81 Cal.Rptr.2d 829 [Feb. 1999]

[No. B119355. Second Dist., Div. Seven. Feb. 1, 1999.]

DOCTOR'S MEDICAL LABORATORY, INC., Plaintiff and Appellant, v. KATHLEEN CONNELL, as Controller, etc., Defendant and Appellant.

COUNSEL

Hooper, Lundy & Bookman and Patric Hooper for Planitiff and Appellant.

Daniel E. Lungren, Attorney General, Linda A. Cabatic, Assistant Attorney General, Marsha A. Bedwell and Christopher C. Foley, Deputy Attorneys General, for Defendant and Appellant.

OPINION

NEAL, J. –

SUMMARY

Federal Medicaid law barred California's Department of Health Services (DHS) – as the "single agency" designated to administer federally funded Medicaid/Medi-Cal payments for medical services for the poor and indigent – from delegating to the state Controller the audit of claims by medical service providers, and the withholding of alleged overpayments.

FACTS AND PROCEEDINGS IN TRIAL COURT

Appellant Doctor's Medical Laboratory, Inc. (hereafter "Doctor's") is a now-defunct firm which formerly provided doctors with laboratory analysis of specimens

of blood, urine, and the like. A large portion of Doctor's income was derived from Medi-Cal patients. Medi-Cal is a State of California program to subsidize medical care for the poor and indigent. Doctor's brought this action to compel respondent Connell, Controller of California, to release approximately $3 million which Doctor's claimed was due for services to Medi-Cal patients.

Medi-Cal payments to patients are funded with federal monies provided under the Medicaid legislation. To obtain federal monies the states must comply with the federal statutory and regulatory requirements of Medicaid. (42 U.S.C. § 1396a(a); *Wilder* v. *Virginia Hospital Assn.* (1990) 496 U.S. 498, 502, [110 S.Ct. 2510, 2513-2514, 110 L.Ed.2d 455].)

Federal law specifies that a state *must designate a single agency* to administer its Medicaid plan (42 U.S.C. § 1396a(a)(5)), and further, forbids the designated agency from delegating, except to its own officials, authority to exercise discretion in administering the plan. (42 C.F.R. § 431.10(e)(1)-(3) (1998).) Federal regulations permit the designated agency to use services of other state agencies, but *not to delegate administrative discretion* to such agencies: "If other State . . . agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency." (42 C.F.R. § 431.10(e)(3) (1998).)

In addition to the single agency and nondelegation requirements, federal law requires states participating in

Medicaid to establish procedures to investigate abuses while protecting providers. (42 U.S.C. §§ 1396a(a)(3), (a)(42); 42 C.F.R. §§ 447.200, 447.202, 455.12-23 (1998).) Carrying out these requirements, California's Welfare and Institutions Code requires DHS to have an administrative appeals process "to review grievances or complaints arising from the findings of an audit or examination. . . . " (Welf. & Inst. Code, § 14171, subd. (a).) California regulations state that "[a] provider may request a hearing . . . to examine any disputed audit or examination finding which results in an adjustment to Medi-Cal program reimbursement. . . . " (Cal. Code Regs, tit. 22, § 51017.) DHS cannot recoup alleged overpayments to a provider until the administrative appeals process is complete, absent special circumstances not present in this case. (Cal. Code Regs, tit. 22, §§ 51017, 51047, subd. (a); Welf. & Inst. Code, § 14170.5, subd. (a).)

California's Medicaid plan, submitted in 1993, certified to the federal government that California's Department of Health Services is the single agency which administers Medi-Cal. A DHS organization chart submitted with California's plan identified a "Fiscal Intermediary Management Division" of DHS. An accompanying description of the Fiscal Intermediary Management Division stated that its Provider Services Section was responsible for all contacts between providers and the State concerning payments, and that its On-Site Management Branch was responsible for audits and reviews concerning accurate payments of claims. The Medi-Cal organization chart also identified an Audits and Investigations Division, whose responsibilities were described in the

plan to include identifying excess payments to medical service providers, and taking corrective action.

DHS contracted with a private entity, called EDS, to review and process provider claims for payment for services rendered to Medi-Cal patients. Federal regulations permit the contracting-out of this function to a private concern. (42 C.F.R. §§ 434.4-434.10 (1998); Welf. & Inst. Code, §§ 14000.3, 14104.3, subd. (a), 14105; Cal. Code Regs., tit. 22, §§ 50007, 51529.) EDS reviews the claims, determines the amount owed, approves the claim, and submits it to respondent Controller for issuance of a check or "warrant" to the provider.

Until mid-1997 the Controller's services to DHS for Medi-Cal were apparently limited to issuing checks, a nondiscretionary activity. In June 1997 DHS entered an Interagency Agreement with the Controller under which the Controller agreed to perform audits to identify overpayments to providers, and to take corrective action, presumably withholding sums believed to constitute overpayment. The agreement stated that "DHS will review all reports of overpayments identified by [Controller] for policy and/or procedural implications."

In late November 1997 Doctor's filed the present suit seeking, inter alia, a writ of mandate compelling the Controller to pay Doctor's approximately $3 million allegedly earned and owed for services to Medi-Cal patients. Doctor's alleged that in September 1997, without notice to Doctor's, the Controller commenced withholding payments due Doctor's and already approved for payment by EDS. Doctor's urged that DHS had

unlawfully delegated its Medi-Cal powers to the Controller, and that the Controller had violated the administrative procedures for dealing with overpayments. Doctor's further claimed that the Controller's refusal to pay the claims had driven Doctor's out of business.

In response to Doctor's suit, the Controller contended that she was justified in withholding payments because Doctor's claims contained insufficient information concerning services provided, and reflected unusually high claims amounts for the services provided.

The trial court rejected Doctor's claim that DHS had illegally delegated audit and overpayment remedial functions to the Controller. However, the trial court found that the Controller was obliged under Government Code section 926.15, subdivision (a), to pay provider claims approved by EDS, less contested amounts, within 30 days after receipt. It granted a writ of mandate ordering the Controller to comply with section 926.15, subdivision (a).

Both sides appealed from the judgment.

DISCUSSION

(1) As a preliminary matter, we reject the Controller's argument that Doctor's lacks standing to bring the present claims. The Controller relies on *Sobky* v. *Smoley* (E.D. Cal 1994) 855 F.Supp. 1123, a federal case holding that methadone recipients and providers lack standing under 42 United States Code section 1983 to enforce the "single state agency" requirement of Medicaid law, because that requirement benefits them only indirectly (through more efficient administration of Medicaid).

However Doctor's sued here for a writ of mandate, made available under California Code of Civil Procedure section 1085. While section 1983 of 42 United States Code requires violation of a private right, privilege, or immunity to confer standing, section 1085 of the California Code of Civil Procedure creates a broad right to issuance of a writ of mandate "to compel performance of an act which the law specifically enjoins." Section 1085 "is available not only to those who have enforceable private rights, but to those who are 'beneficially interested' parties within the meaning of Code of Civil Procedure section 1086." (*California Homeless & Housing Coalition* v. *Anderson* (1995) 31 Cal.App.4th 450, 458 [37 Cal.Rptr.2d 639] [per Chin, J., homeless coalition has standing despite *Sobsky* rule to seek mandamus compelling state agency to comply with federal AFDC law].)

Doctor's is a "beneficially interested party" and has standing to pursue its action in mandamus against the Controller.

We turn to the merits.

(2) State participation in Medicaid is voluntary, but once a state elects to participate and receive federal funds, it is obliged to fully comply with federal statutes and regulations. (*Frank* v. *Kizer* (1989) 213 Cal.App.3d 919, 923 [261 Cal.Rptr. 882].)

(3) As noted above, federal Medicaid statutes and regulations require designation of a single state agency to administer a state's Medicaid program, and further, forbid delegation of the agency's power to make administrative judgments or decisions about the application of the

agency's policies, rules and regulations. Consistent with these provisions, California's Medi-Cal plan affirmed compliance with the single agency requirement and stated that auditing of provider claims and recapture of overpayments would be done by DHS.

The interagency agreement, however, authorized the *Controller* to audit provider claims and "take corrective action." Delegation of these powers to the Controller was contrary to DHS's representation to the federal government (in DHS's Medicaid plan) that *audits and corrective action would be DHS's province.* Further, the authority extended to the Controller to "take corrective action" was authority to change or disapprove prior decisions by DHS's agent (EDS) to pay provider claims. This transfer of authority from DHS to the Controller violated the federal statutory and regulatory bar on delegation by the "single designated agency" of discretionary authority. It improperly empowered the Controller to "change or disapprove" administrative decisions by DHS and its agent.

The interagency agreement's recitation that "DHS will review all reports of overpayments identified by [Controller] for policy and/or procedural implications" does not save the delegation of authority from violating federal law. The express ban on delegating discretionary power contains no exception permitting delegation so long as decisions are later "reviewed" (in some unspecified manner) by the designated "single agency." The bar to delegation of discretionary power would be easily circumvented if such a provision in an interagency agreement were given effect.

The Controller could not lawfully exercise power to audit provider payments and withhold alleged excesses.[1]

The Controller argues that she has an independent duty under California law to supervise payments from the treasury of California. While this is generally true, California modified this duty with respect to Medi-Cal payments by accepting federal monies and agreeing to be bound by federal laws requiring designation of a single California agency to administer those payments.

Neither side has cited legislative history or case law discussing the legislative and regulatory reasons for the single agency and non-delegation rules. But the circumstances of the present case suggest some of these reasons. First, such rules, if adhered to, avoid the delay entailed when several state agencies in succession review claims before payment is made. Here, DHS's agent, EDS, approved the claims, but then the Controller held them up. Second, the rules offer a degree of assurance that state agencies reviewing provider claims will have knowledge and expertise concerning medical expense claims and the peculiar rules and regulations which govern Medicaid claims. By contrast, a non-specialized agency such as the Controller, newly embarked on the business of reviewing medical provider claims, might well lack the expertise needed for prompt, fair review.

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[1] While it is not controlling precedent, we note that the federal District Court for the Central District of California reached the same conclusion as we do, on the same reasoning, in its unpublished decision filed April 9, 1998, in *Health Line Clinical Laboratory, Inc.* v. *Connell*, (U.S. Dist.Ct. (C.D.Cal.)) No. CV-98-1620-RJK.

And of course, prompt, knowledgeable, fair review and payment of provider claims are essential to the basic statutory purpose to provide medical care to the indigent and elderly. Private providers will soon be discouraged from offering Medicaid services if they are not paid promptly and fairly for their services. Indeed, providers will not be *able* to provide such services if they go out of business because the state improperly withholds payments – as Doctor's alleges occurred here.

In accordance with the foregoing, we will modify the trial court's judgment to require that the Controller release all sums which EDS has approved for payment to Doctor's, without prejudice to subsequent audits and claims for overpayment by DHS, in compliance with the governing rules and regulations.

DISPOSITION

The judgment of the trial court is modified to require Controller to forthwith pay to Doctor's all amounts approved for payment by the Department of Health Service's Fiscal Intermediary, EDS. As so modified, the judgment is affirmed. Plaintiff and Appellant shall recover its costs on appeal.

LILLIE, P.J, and JOHNSON, J., concur.

A petition for a rehearing was denied March 3, 1999, and the petition of defendant and appellant for review by the Supreme Court was denied May 26, 1999. Kennard, J., and Brown, J., were of the opinion that the petition should be granted.